Documents for the Record 10/19/23

Majority:

- October 19, 2023, statement from ASCO
- October 19, 2023, statement from AANP
- October 19, 2023, statement from ACEP
- October 19, 2023, statement from AMA (submitted by Rep. Burgess)
- Statement from AOTA
- October 19, 2023, statement from ASM
- October 19, 2023, statement from AUA (submitted by Rep. Burgess)
- October 19, 2023, statement from ACS (submitted by Rep. Bucshon)
- 2019 Cost Report (submitted by Rep. Burgess)
- October 19, 2023, statement from AOA (submitted by Rep. Burgess)
- October 16, 2023, letter from coalition of national medical societies
- October 19, 2023, letter from Society for Vascular Surgery
- October 19. 2023, statement from American Academy of Dermatology Association (submitted by Rep. Joyce)
- December 2, 2022, white paper from American Academy of Orthopedic Surgeons

Minority:

- October 19, 2023 statement from the American Hospital Association
- October 18, 2023 letter on APMs

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Statement prepared for:
U.S. House Committee on Energy and Commerce Subcommittee on Health

What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors

October 19, 2023

The Association for Clinical Oncology (ASCO) is pleased to submit this statement for the record of the hearing entitled, "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." ASCO appreciates the Subcommittee holding today's hearing to discuss policy reforms to create a more sustainable Medicare physician reimbursement system.

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 Subcommittee'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 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.[1,2,3,4,5] 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, 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) standards 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 ninety-five cancer care sites and nearly five hundred oncologists from twelve 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.

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[1] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[2] https://ascopubs.org/doi/full/10.1200/OP.21.00644
[3] https://www.astro.org/ASTRO/media/ASTRO/News%20and%20Publications/PDFs/ASTROPriorAuthorizationPhysician- SurveyBrief.pdf
[4] https://old-prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-November-2022.pdf
[5] https://www.mgma.com/getmedia/788a1890-8773-4642-9c22-b224923e4948/05-03-2023_PA-in-MA_FINAL.pdf.aspx?ext=.pdf

Additionally, ASCO's Quality Oncology Practice Initiative (QOPI®) Certification Program 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), 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 six-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.

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 one-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 six 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. In the Consolidated Appropriations Act of 2023, Congress reduced the proposed 4.5% cut to Medicare physician payments by increasing the 2023 conversion factor by 2.5%.

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). 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 appreciates and supports the Subcommittee's consideration of the *Providing Relief and Stability for Medicare Patients Act of 2023* (H.R. 3674) and the *Provider Reimbursement Stability Act of 2023*, 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 five years. Lastly, both bills would address over- and under-utilization 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 payment 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

[6] 2021 Quality Payment Program Experience Report. Available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2433/2021%20QPP%20Experience%20Report.pdf

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 sunsetting 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 MPFS.

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 MPFS 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 under the Consolidated Appropriations Act of 2022 for one year through 2023, with a 3.5% incentive payment for services covered in the 2023 performance year. The legislation also extended the current freeze on participation thresholds for qualification for APM bonuses for an additional year. 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 Rep. Dunn's legislation to *extend incentive payments for eligible APMs for 5 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.

Lastly, ASCO appreciates the inclusion of the *SURS Extension Act* (H.R. 5395) in today's hearing. This legislation would extend CMS' Quality Payment Program-Small Practice, Underserved, and Rural Support program. Often, providers and practices in underserved or rural communities struggle to participate in the QPP due to a lack of resources and therefore require additional technical support.

Regulatory Relief and Patient Access

In addition to the harmful effects of inflation, practices are confronted daily with a growing number of utilization management policies payers use in attempts to lower costs. ASCO understands concerns about increased health care spending and supports the delivery of high-value care. However, we are concerned these practices are harming patients. They take clinician time away from patient care, increase practice expense with additional administrative workload, often delay treatment, and may require patients to travel long distances for additional appointments. We are in strong support of efforts to lift this burden from patients with cancer and the clinicians who care for them.

Regulatory Relief

An ongoing source of frustration across the oncology care team is overly burdensome prior authorization requirements. ASCO recently published the results of a U.S. member survey to assess the impact of prior authorization on cancer care.

Nearly all survey participants reported a patient has experienced harm because of prior authorization mandates, including significant impacts on patient health such as disease progression (80%) and loss of life (36%). The most widely cited harms to patients reported were delays in treatment (96%) and diagnostic imaging (94%); patients being forced onto a second-choice therapy (93%) or denied therapy (87%); and increased patient out-of-pocket costs (88%).

The survey responses also reflected the difficulties of the prior authorization mandates. Nearly all respondents report experiencing burdensome administrative requirements, delayed payer responses, and a lack of clinical validity in the process. The survey also found that on average:

- It takes a payer five business days to respond to a prior authorization request.
- A prior authorization request is escalated beyond the staff member who initiates it 34% of the time.
- Prior authorizations are perceived as leading to a serious adverse event for a patient with cancer 14% of the time.
- Prior authorizations are "significantly" delayed (by more than one business day) 42% of the time.

Over the past several years, Members of Congress have become increasingly concerned about the use of prior authorization in MA plans. The House of Representatives unanimously passed the *Improving Seniors' Timely Access to Care Act* (S. 3018/H.R. 3173) in September 2022. This bipartisan legislation,

developed with input from ASCO, finished the 117th Congress with 380 combined cosponsors — 53 senators and 327 representatives — supporting the legislation. Importantly, more than 500 organizations representing patients, health care providers, the medical technology and biopharmaceutical industry, health plans, and others endorsed the legislation.

While the legislation did not pass the Senate last Congress, ASCO is optimistic that the CMS Electronic Prior Authorization proposed rule, which was published in the Federal Register on December 13, 2022, takes steps to improve the prior authorization requirements that will improve beneficiary access to necessary and lifesaving services and ease the administrative burden on physicians and payers. This rule aligns with many of the provisions included in the legislation, which, if passed, would have gone into effect in 2024.

Both this proposed rule and the legislation:

- Establish an electronic prior authorization program.
- Standardize and streamline the prior authorization process.
- Increase transparency around MA prior authorization requirements and their use.

We strongly urge CMS to address two overarching concerns with the proposed rule to maintain current regulatory and legislative momentum to address prior authorization:

1. Expedite the implementation timeline of provisions finalized in this rule for all plans and require compliance with finalized proposals in contract year 2024.
2. Include drugs—which are currently excluded—in the electronic prior authorization program and application programming interface (API) requirements.

ASCO appreciates the 233 Representatives and 61 Senators who signed letters, including 23 members of the Energy and Commerce Committee, to CMS urging the agency to finalize and implement the proposed rule, as well as urging CMS to expand on the rule to allow for some real-time electronic prior authorization decisions, require a response within 24 hours for urgently needed care, and increase transparency.

ASCO appreciates the inclusion of the *Improving Seniors' Timely Access to Care Act* in this hearing and looks forward to continuing to work with the Subcommittee members to address this burdensome issue plaguing our health care system.

Real-Time Benefit Accessibility

Provider accessibility to real-time benefit information plays a critical role in timely care delivery. ASCO supports the proposal led by Rep. Arrington *to promote provider choice using real-time benefit information.* Specifically, ASCO supports a "real-time benefit tool (RTBT)" that allows insurers to electronically send formulary and benefit information to prescribing clinicians, using technology that integrates with clinicians' electronic prescribing and electronic health record (EHR) systems. Such transactions, when integrated into qualified EHRs, could increase efficiencies. ASCO also supports awarding credit to physicians using RTBTs under MIPS.

Telehealth Privacy

Telehealth has served as an essential resource in cancer care delivery, especially for those in rural and underserved communities. ASCO appreciates Congress' extension of telehealth flexibilities and allowance of services under Medicare through 2024. As Medicare continues to regulate telehealth services, we are concerned with specific privacy gaps for providers. Specifically, Medicare recently proposed requiring providers to include their home addresses on Medicare enrollment forms if telehealth services are performed at their homes. To protect provider information, we support the *Telehealth Privacy Act of 2023*, which is up for discussion in this hearing. The legislation would prohibit Medicare from making provider's home addresses publicly accessible.

Patient Access to Treatments

In addition, ASCO is concerned about the increasing barriers for patients to access their treatments. Some oncology practices have in-office pharmacies, allowing physicians to trust that their patients receive intended drug treatment with appropriate instructions. If a patient is unable to come to the office, a physician should be able to mail or otherwise send a prescription securely to a patient or have a trusted surrogate pick up prescriptions on behalf of the patient. Studies[7] have shown that integrated pharmacy services may increase patient adherence to medication. However, a CMS determination[8][9] states that delivery of medicine to a patient using the U.S. Postal Service or other trusted service violates the in-office exception of the Stark Law.

We support and appreciate the Subcommittee's consideration of the *Seniors' Access to Critical Medications Act of 2023* (H.R. 5526), which aims to clarify the in-office ancillary services exception to the physician self-referral law to allow drugs to be mailed to Medicare patients. This bipartisan legislation would clarify that a surrogate may deliver medicine dispensed at a physician-owned pharmacy without violating the law. This critical legislation will reduce patient barriers to treatment and allow patients and providers to focus on the treatment plan.

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 Megan Tweed at Megan.Tweed@asco.org with any questions.

[7] Iuga A, & McGuire M. Adherence and health care costs. Risk Manag Healthc Policy. 2014; 7: 35–44.
May B. ASCO/NCODA Release Standards for Medically Integrated Dispensing of Oral Anticancer Drugs. The ASCO Post. December 25, 2019. https://ascopost.com/issues/december-25-2019/asconcoda-release-standards-for-medically-integrated-dispensing-of-oral-anticancer-drugs/

[8] Centers for Medicare & Medicaid Services. Physician Self-Referral. (2023). https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/index

[9] CMS Physician Self-Referral Law FAQs. https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/FAQs-Physician-Self-Referral-Law.pdf

Statement for the Record
American Association of Nurse Practitioners
For the United States House Committee on Energy and Commerce
Subcommittee on Health
"What's The Prognosis?: Examining Medicare Proposals To Improve Patient Access To Care & Minimize Red Tape For Doctors"
October 19, 2023

On behalf of the more than 355,000 nurse practitioners (NPs) across the nation, the American Association of Nurse Practitioners (AANP) appreciates the opportunity to provide the following statement for the record to the United States House Energy and Commerce Subcommittee on Health. We commend committee Chairwoman McMorris Rodgers and Ranking Member Pallone, subcommittee Chairman Guthrie and Ranking Member Eshoo and the members of the subcommittee, particularly bill sponsor Representative Blunt Rochester, for including H.R. 2583 the *Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023,* in the discussion during this hearing. This legislation has broad support within the health care community and would build upon the *Bipartisan Budget Act of 2018*'s (BBA's) (Pub. L. 115–123) authorization for NPs (and physician assistants (PAs) and clinical nurse specialists (CNSs)) to supervise cardiac rehabilitation and pulmonary rehabilitation by also authorizing these providers to order cardiac and pulmonary rehabilitation services. While cardiac and pulmonary rehabilitation are lifesaving services, they are severely underutilized. This legislation will increase patient access to these critical programs, particularly in rural and underserved communities, as well as help to alleviate health care disparities. AANP also appreciates the subcommittee's consideration of H.R. 4104, the *Preserving Patient Access to Home Infusion Act*. Specifically, AANP supports Section 2, subsection (c) of that legislation which would authorize NPs and PAs to establish and review home infusion plans of care for Medicare patients.

Background on Nurse Practitioners

NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and backgrounds. Daily practice includes assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities. NPs hold prescriptive authority in all 50 states and the District of Columbia (D.C.) and perform more than one billion patient visits annually. Currently, twenty-seven states, the District of Columbia and two U.S. territories have adopted full practice authority, granting patients full and direct access to nurse practitioners[1].

[1] https://www.aanp.org/advocacy/state/state-practice-environment

NPs practice in nearly every health care setting including hospitals, clinics, Veterans Health Administration and Indian Health Services facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), skilled nursing facilities (SNFs) and nursing facilities (NFs), schools, colleges and universities, retail clinics, public health departments, nurse managed clinics, homeless clinics and home health care settings.

Nurse practitioners provide a substantial portion of the high-quality[2], cost-effective[3] 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] According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[7] 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).[8] NPs are an essential element to addressing some of our nation's greatest health care challenges and have demonstrated that they provide high-quality care in a cost-effective manner.

NPs provide a substantial 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.[9,10,11] 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."[12] NPs are also the second largest provider group in the National Health Services Corps[13] and the

[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf
[4] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[5] *Ibid*.
[6] NP Fact Sheet (aanp.org)
[7] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[8] https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19
[9] 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
[10] 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. https://jamanetwork.com/journals/jama/fullarticle/2720014
[11] 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
[12] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/
[13] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf

number of NPs practicing in community health centers has grown significantly over the past decade.[14] Rural communities are disproportionately impacted by health care inequities, which are exacerbated when communities experience rural hospital closures. 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)."[15]

Decades of evidence demonstrate the high-quality, cost-effective care that NPs provide to their patients, including patients with cardiovascular and pulmonary disease who would qualify for cardiac and pulmonary rehabilitation. NPs are particularly skilled at these types of clinical interventions and help patients manage their conditions through their whole-person centered approach to health care delivery. NPs were early adopters of the Patient Centered Medical Home model which successfully incorporates care coordination, care planning and consistent patient outreach, and nurse-managed health clinics are vital sources of care to patients with acute and chronic conditions in rural and underserved communities. Authorizing NPs to order cardiac and pulmonary rehabilitation will reduce barriers to care for patients in need of these services and improve the ability of NPs to ensure their patients receive this medically necessary care in a timely manner.

Importance of Increasing Access to Cardiac and Pulmonary Rehabilitation

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) or COVID-19 symptoms that include respiratory dysfunction for at least one month. Heart disease remains the leading cause of death in the United States with nearly 700,000 deaths per year.[16] 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.[17] COPD is the sixth leading cause of death in the United States, with nearly 150,000 deaths per year.[18] COPD is estimated to cost the United States nearly $50 billion annually in related health care expenditures and indirect mortality and morbidity costs.[19]

[14] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[15] https://www.gao.gov/assets/gao-21-93.pdf
[16] https://www.cdc.gov/heartdisease/about.htm
[17] 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.
[18] https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-mortality
[19] https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-burden

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 Medicare patients receive cardiac rehabilitation and only three percent of Medicare patients with COPD receive pulmonary rehabilitation.[20,21,22] Participation rates are even lower for female and minority patients and those who live outside metropolitan areas or in lower income urban areas.[23,24] For instance, one study found that female, black, Hispanic, and Asian patients were 12%, 20%, 36% and 50% less likely to be referred for cardiac rehabilitation, respectively.[25] 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.[26]

In an effort to increase Medicare patients' access to cardiac and pulmonary rehabilitation, Congress authorized NPs to supervise cardiac and pulmonary rehabilitation beginning in 2024 as part of the BBA. The Centers for Medicare and Medicaid Services (CMS) earlier this year issued the 2024 proposed rule for the Medicare physician fee schedule, which included proposals to implement the BBA's authorization for NPs to supervise these programs.[27] However, CMS recognized that even with the supervision authorization, additional barriers still remain that limit patient access to cardiac and pulmonary rehab, including "a lack of referral or strong recommendation from a physician and inadequate follow-up or facilitation of enrollment after referral."[28]

Therefore, further modernization of Medicare is still needed to authorize NPs to order these services for their patients. Removal of this outdated barrier will enable Medicare patients to have timely access to these critical programs. While an NP may be the primary care provider for a patient and be most familiar with the patient's health care needs, under current law, the NP must refer the patient to a physician to order these services. The Medicare program generally authorizes NPs to perform or order any Medicare-covered services in accordance with state law, and the barrier regarding ordering of cardiac and pulmonary rehabilitation is an outlier in this respect.

[20] https://millionhearts.hhs.gov/data-reports/factsheets/cardiac.html
[21] https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.119.005902
[22] https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC
[23] 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.
[24] 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.
[25] Li, S., Fonarow, G.C., Mukamal, K., Xu, H., Matsouaka, R.A., Devore, A.D., & Bhatt, D.L. (2018). Sex and racial disparities in cardiac rehabilitation referral at hospital discharge and gaps in long-term mortality. Journal of the American Heart Association. 7(8). Doi: 10.1161/JAHA.117.
[26] https://www.ahajournals.org/doi/10.1161/JAHA.117.006404
[27] https://www.govinfo.gov/content/pkg/FR-2023-08-07/pdf/2023-14624.pdf
[28] *Ibid.*

The Center for Medicare and Medicaid Innovation (CMMI) has also recognized that the physician ordering requirement reduces access to cardiac and pulmonary rehabilitation. CMMI has created the ACO Realizing Equity, Access, and Community Health (REACH) model that waives several barriers for NPs and their patients in participating ACOs, including the barrier on ordering cardiac and pulmonary rehabilitation. CMMI stated that authorizing NPs to order cardiac rehabilitation "is expected to increase an NP's involvement in a REACH beneficiary's heart treatment, improving quality by easily connecting REACH Beneficiaries to these critical treatments when medically necessary and appropriate, and reducing cost by decreasing the number of clinician visits that a REACH Beneficiary would need to obtain these services."[29]

NPs are clinically trained to provide high-quality and timely care to patients in need of cardiac and pulmonary rehabilitation. Authorizing NPs to order these safe and effective services will allow them to be involved in their patients' cardiac and pulmonary rehabilitation care from start to finish, creating greater continuity of care and access for patients in need of these underutilized services.

Support for Removing Barriers to Practice on Nurse Practitioners

H.R. 2583 is supported by a broad coalition of organizations. In addition to AANP, the bill is supported by the American Academy of PAs, American Association for Respiratory Care, American College of Cardiology, American Heart Association, American Lung Association, American Nurses Association, American Thoracic Society, National Rural Health Association, Preventive Cardiovascular Nurses Association and WomenHeart.

In addition to bipartisan support in Congress, reports issued by the American Enterprise Institute,[30] the Brookings Institution,[31] the Federal Trade Commission[32] and the U.S. Department of Health and Human Services under multiple administrations[33,34,35] have all highlighted the positive impact of removing barriers on NPs and their patients. The National Academy of Medicine report *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity* also recommended that "all relevant state, federal and private organizations enable nurses to practice to the full extent of their education and training by removing practice barriers that prevent them from more fully addressing social needs and social determinants of health and improve health care access, quality, and value."[36] The World Health Organization's *State of the World's Nursing 2020* report similarly recommends modernizing regulations to authorize APRNs to practice to the full extent of their

[29] https://www.cms.gov/priorities/innovation/media/document/aco-reach-rfa
[30] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf
[31] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf
[32] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy
[33] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[34] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners
[35] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf
[36] https://www.nap.edu/resource/25982/FON%20One%20Pagers%20Lifting%20Barriers.pdf

education and clinical training, noting the positive impact it would have on addressing health care disparities and improving health care access within vulnerable communities.[37]

Improving Access to Home Infusion Therapy for Medicare Patients

AANP also supports Section 2, subsection (c) of H.R. 4104, the *Preserving Patient Access to Home Infusion Act* which would authorize NPs and PAs to establish and review home infusion plans of care for Medicare patients. Even though NPs and PAs are "applicable providers" who are authorized to be the attending care provider for a patient receiving home infusion therapy, Medicare still requires NPs and PAs to have a physician establish and review the patient's plan of care. NPs are authorized to establish and certify home health care plans of care, but this home infusion barrier limits the ability of NPs to obtain home infusion services for their patients. This barrier restricts the ability of patients to receive care in their setting of choice, leads to delays in care delivery and undermines care continuity.

Conclusion

AANP appreciates the subcommittee's inclusion of H.R. 2583, the *Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023,* and H.R. 4104, the *Preserving Patient Access to Home Infusion Act,* in this hearing. We urge the Energy & Commerce Committee to consider and advance it. We look forward to working with the subcommittee on further efforts to improve access to high-quality, medically necessary care for all patients. Should you have any comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

[37] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

October 19, 2023

The Honorable Brett Guthrie
Chair
House Committee on Energy and Commerce
Subcommittee on Health
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
272 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Eshoo,

On behalf of the American College of Emergency Physicians (ACEP) and our 40,000 members, thank you for the hosting the legislative hearing entitled, "What is the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." We deeply appreciate the opportunity to provide our comments and recommendations for establishing a more affordable and sustainable health care system that ensures our patients have access to the high-quality care they need and deserve. As we all work together to better carry out the goals of the Medicare Access and CHIP Reauthorization Act (MACRA; P.L. 114-10) and transition to a health care system that incentivizes the delivery of efficient, high-value care, it is critical that emergency physicians, and all physicians, are able to meaningfully participate in innovative new payment models and pathways, while also ensuring that Medicare payments for physician services are not only stable, but also account for inflation reflective of contemporary financial realities.

MACRA was intended to permanently resolve Medicare's flawed Sustainable Growth Rate (SGR) payment formula and transition our health care system to one that rewards value, rather than volume. As we looked to move away from fee-for-service (FFS) as the standard, MACRA was designed to establish value-based payment pathways – the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) – as well as streamline the numerous quality reporting programs under Medicare.

However, the implementation of MACRA has not proven to be the fix that was promised. While the law helped avoid short-term physician payment issues, according to the 2022 Medicare Trustees Report, there are "…important long-range concerns that will almost certainly need to be addressed by future legislation."[1] In fact, the Trustees project that by 2048, physician payments under Medicare will be lower under MACRA than they would have been if the SGR had remained in effect. The Trustees note that without changes, future access to Medicare-participating physicians will become a significant long-term problem. ACEP strongly agrees with this assessment.

We believe that with improvements, developed through collaboration with Congress, regulators, and stakeholders as originally intended, MACRA can be significantly more effective in facilitating the transition to value-based care delivery. Improvement does not necessitate the wholesale dismantling of the current system as with the SGR but does require more regular management to help us attain a sustainable payment system that truly incentivizes high-quality, cost-effective care and to ensure that we do not expend our time and resources in vain trying to achieve that ultimate goal.

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[1] Pollock JR, Hogan JS, Venkatesh AK, et al. Group Practice Size Consolidation in Emergency Medicine. Annals of Emergency Medicine. 2022;79(1):2-6. doi:10.1016/j.annemergmed.2021.07.122

Fundamental Issues Regarding Medicare Payment Stability

The emergency department (ED) serves as the "front door" to the health care system, receiving 150 million visits each year, with more and more of our patients older in age and arriving via emergency medical services (EMS) transport. Of these visits, 16 to 18 percent of patients are admitted to the hospital, accounting for approximately two-thirds of all inpatient admissions nationwide.[2] And for many Americans, the ED may be the first – and only – interaction they have with the health care system, especially for safety-net and otherwise underserved populations.

Given this foundational role that emergency physicians and other ED clinicians play in our health care system, we believe that we should be at the center of value-based payment initiatives. However, one of MACRA's most fundamental flaws is the failure to appropriately integrate emergency care into the transition to value-based care. MACRA, and most health care delivery reforms and APMs, have focused on primary care and chronic disease management for the purpose of decreasing the need for acute care and reducing ED utilization and spending. But neglecting to incorporate acute care delivery in large-scale system redesign perpetuates an incorrect and harmful notion of the ED as a "failure" of the health care system, rather than recognizing the unique role of emergency physicians as the safety net who care for people at their greatest time of need. As a result, emergency physicians have largely been left out of opportunities to meaningfully engage in Accountable Care Organizations (ACOs) and other APM initiatives, including the Advanced APM pathway under MACRA's Quality Payment Program (QPP). Emergency physicians essentially have no other option than to participate in and report under measures in the Merit-based Incentive Payment System (MIPS), which can be burdensome and includes some underlying flaws that truly hinder its ability to help clinicians improve the quality of care they provide and reduce health care costs.

MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly "Meaningful Use"). Performance on these four categories roll up into an overall score that translates to an upward, downward, or neutral payment adjustment provided two years after the performance period. The maximum penalty is 9 percent, while the maximum bonus is dynamic and adjusted to preserve overall budget neutrality. In other words, CMS first determines which clinicians will receive a penalty, then uses that pool of penalties to pay out bonuses. MIPS, as opposed to the APM paradigm, is effectively a one-size-fits-all system as all participants are weighed against each other in these same categories and measures regardless of specialty. But this one-size-fits-all system is not capable of accounting for the differences in how care is delivered for episodic, acute unscheduled care compared to primary care or other non-episodic scheduled care. While the MIPS Value Pathways (MVP) approach, described later, attempts to resolve this concern, we are concerned that the current structure of MVPs is not dissimilar enough from traditional MIPS as to provide an attractive alternative to traditional MIPS reporting.

ACEP shares your desire to stabilize the Medicare payment system without dramatic increases in Medicare spending, but even with all necessary improvements to MACRA, this goal is unachievable without addressing the root of this instability. We firmly believe any effort that seeks to comprehensively address the stability of Medicare physician payments will be incomplete without resolving key structural problems in the system, chiefly, Medicare's "budget neutrality" requirements and the lack of an inflationary measure tied to physician payments. Annual updates to physician payments already fail to keep up with the cost of providing physician services, and additional large-scale payment reductions such as those imposed by budget neutrality and sequestration will make it even more difficult for many physician specialties like emergency medicine (EM) to continue providing care.

In the 2024 Physician Fee Schedule (PFS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) proposes a conversion factor of $32.7476, a decrease of $1.1396 or 3.36 percent from the calendar year (CY) 2023 PFS conversion factor of $33.88726. Emergency medicine reimbursement in 2024 is estimated to decrease by 2 percent, not including an additional across-the-board reduction of 1.25 percent. The proposed update is primarily based on three factors: a statutory 0% update scheduled for the PFS in CY 2024, a negative 2.17% budget neutrality adjustment, and a funding patch passed by Congress at the end of CY 2022 through the Consolidated Appropriations Act, 2023 (CAA). This bipartisan legislation partially mitigated the conversion factor cut by providing a 2.5% increase for the CY 2023 conversion factor but only a 1.25% increase to offset part of the reduction to the CY 2024 CF. Separate from the PFS CF, the CAA, 2023 also waived the pay-as-you-go Act (PAYGO) 4% reduction for two years (for 2023 and 2024). Thus, we have multiple concerns about the compounding of factors that will cause difficulty for many specialties to continue providing care, including emergency medicine, which threatens the existence of the country's health care safety net.

[2] https://www.acepnow.com/article/long-term-trends-emergency-department-visits-patient-care-highlighted-nationalreports/?singlepage=1

Given that annual updates to physician payments already fail to keep up with the cost of providing services, adding large-scale payment reductions will only make it even more difficult for many physician specialties, including EM, to continue providing care. Medicare's access problems present differently for EM when compared with other specialties and primary care. While continued cuts and insufficient reimbursement may incentivize other physician specialties to ultimately opt out of Medicare, emergency physicians are essentially required to participate given Emergency Medical Treatment and Labor Act (EMTALA) as well as the nature of emergency medicine as a hospital-based specialty. And as economic incentives and continued system consolidation have encouraged hospitals to outsource physician specialties like EM and others, emergency physicians tend to practice in groups – small, mid-size, or large – that contract with a hospital or system to provide emergency care. Since emergency physicians must treat every patient that walks through the doors of the ED, regardless of insurance status or ability to pay, these contracts almost always require the emergency physician group to participate in Medicare. In theory, these dynamics would guarantee access to emergency care regardless of the reimbursement environment; however, as physician payments continue to decrease, new generations of physicians will have fewer incentives to pursue EM when compared with other more competitive and financially-viable specialties that provide greater freedom of practice, creating challenges for hospitals to try and keep the ED doors open with sufficient staff.

Financial stability and certainty are critical in ensuring that Medicare can fulfill its promise to the millions of American seniors that deserve and depend upon this program. The annual issue of significant Medicare payment cuts not only threatens the viability of the health care safety net, but also affects our ability to effectively partner with Congress to address other critical challenges facing the physician community, and most importantly, our ability to advocate on behalf of our patients. We share legislators' significant frustrations with the perennial task of finding costly, short-term fixes for long-term problems.

Recommended Changes: Eliminate the Budget Neutrality Requirement

As noted above, the PFS includes an arbitrary budget neutrality requirement, mandating an overall across-the-board adjustment to the conversion factor if any changes in relative value units (RVUs) result in Medicare payments being increased by greater than $20 million. This policy truly pits specialties against each other, as any upward adjustment to a particular code results in an automatic reduction to the conversion factor—which has a greater practical impact on those clinicians who do not typically bill that code. This unfortunate policy result played out most acutely during the CY 2021 PFS and QPP rulemaking cycle where CMS increased the office and outpatient evaluation and management (E/M) codes often used by primary care as well as created an add-on code for complexity. These policies resulted in a 10.2 percent reduction to the CY 2021 PFS conversion factor, which Congress fortunately mitigated in the Further Consolidated Appropriations Act, 2020 (P.L. 116-94.) Without congressional action, all clinicians would have been negatively affected by this 10.2 percent conversion factor reduction, but primary care physicians, who typically bill the office and outpatient E/M services would have overall actually come out ahead and benefited. Therefore, these clinicians were not as concerned about this significant cut to the conversion factor, while specialists who did not bill these codes, such as emergency physicians and other specialists, were extremely anxious about how the cut would impact their practices. This discrepancy in how the budget neutrality requirement affects different clinicians depending on which codes are modified is fundamentally unfair and not how a viable payment system should operate. Certain clinicians should not be penalized simply because other clinicians were provided with a much-needed increase in a particular year.

ACEP strongly believes that the budget neutrality requirement must be eliminated. As an alternative, ACEP supports proposals to increase the budget neutrality trigger of $20 million, as the $20 million cap was established in 1989 and has not been updated since its creation. Thus, the trigger threshold should be increased to $100 million to better account for past inflation. We firmly believe any effort that seeks to comprehensively address the stability of Medicare physician payments will be incomplete without resolving key structural problems in the budget neutrality requirements and the lack of an inflationary measure tied to physician payments. Annual updates to physician payments already fail to keep up with the cost of providing physician services, and additional large-scale payment reductions such as those imposed by budget neutrality and sequestration will make it even more difficult for many physician specialties like emergency medicine to continue providing care. Medicare rates were never designed to represent the fair market value of health care services or to even cover provider costs, and they fluctuate based on variables unrelated to the services provided. They function more as a federal budget mechanism rather than as a full representation of the value of the physician service.

We ask Congress to fully consider the effects of the fluctuations of market value under the current, outdated framework of budget neutrality and its constraints and identify methods to alleviate this growing uncertainty. CMS should use the full extent of its regulatory authority to prevent or at the very least minimize negative impacts on physicians, and we also continue to urge Congress to eliminate budget neutrality (or alternatively, increase the trigger to at least $100 million to account for past inflation),

exempt benefits or services for which utilization is expected to increase due to changes in law or regulations from budget neutrality adjustments, and to implement an inflationary adjustment measure to the PFS so that physician payments are appropriately updated like other Medicare participants.

ACEP also believes that benefits or services for which utilization is expected to increase due to changes in law or regulations should be exempt from budget neutrality adjustments, including:

- Newly covered Medicare services
- Services that are being incentivized
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures
- Benefit or access expansions
- New technology

APMs and Emergency Medicine

As mentioned previously, emergency physicians play a vital role in their communities, providing a safety net for individuals during their greatest time of need. As they treat each patient, emergency physicians must make the critical decision about whether the patient should be kept for observation, admitted to the hospital, or discharged. Essentially, they act as a gateway to the hospital for many patients. Emergency physicians are therefore in a prime position to be meaningful participants in APMs that attempt to shift our health care system to one that rewards value over volume. However, while many emergency physicians are ready to take on the downside risk and participate in Advanced APMs, there simply are not any opportunities to do so.

In order to address the gap in available Advanced APMs for emergency physicians, ACEP developed an emergency medicine-focused APM, the Acute Unscheduled Care Model (AUCM; affectionately pronounced "awesome"), that we have presented to regulators for incorporation into various APM initiatives. ACEP established an internal APM Task Force to review various APM proposals, eventually resulting in the development of the AUCM. In October 2017, ACEP submitted the AUCM proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Established by MACRA, the PTAC is tasked under statute with commenting on and recommending physician-focused APM proposals to the Secretary of Health and Human Services (HHS) for consideration, based on a set of ten criteria established by the Secretary. After months of discussions with a Preliminary Review Team (PRT) within the PTAC, ACEP officially resubmitted the model in June 2018.

In September 2018, three emergency physicians presented the model to PTAC during a public meeting. PTAC voted on the ten criteria and determined that the AUCM proposal met all ten criteria.

The PTAC then voted to submit the model to the HHS Secretary for full implementation, agreeing that the model has great potential to improve the way emergency care is delivered and that it fills a huge gap in the current portfolio of APMs. One member of the PTAC even stated that it was the best APM that they had reviewed to that point. Based on the vote and recommendations made during this meeting, PTAC then formally issued a report to the HHS Secretary in October 2018 stating that AUCM deserves priority consideration based upon the scope criterion.

In September 2019, HHS Secretary Alex responded[3] to the PTAC's recommendation by stating that he was, "interested in exploring how the concepts in the AUCM model for care management by emergency physicians after an ED encounter could be incorporated into models under development at the CMS Center for Medicare and Medicaid Innovation (CMMI)." But despite subsequent conversations, CMMI has not made any tangible progress on the implementation of the model at this point.

ACEP has repeatedly raised our concerns with CMS that the agency is not doing enough to engage emergency physicians in value-based payment initiatives. Most recently, in our response to the CY 2023 PFS and QPP proposed rule, ACEP reiterated our call that CMS prioritize the creation of additional APM opportunities for emergency physicians and other specialists, or determine how to modify existing APMs to better engage specialists and allow them to actively participate. We urge Congress to exercise its oversight role to examine why have largely been precluded from participating in APMs.

At this point, we are trying to work with other payors beyond Medicare to try to advance the principles of the AUCM. We created our own initiative to promote participation in emergency medicine-focused APMs offered by Medicaid and private payors. As these payors also move away from traditional FFS contracts toward value-based payment arrangements, the AUCM

[3] https://downloads.cms.gov/files/ptac-hhssecresponse-sep18-dec18.pdf

could be an ideal APM construct for them to adopt, at least in terms of core concepts. We anticipate that some features of these private payor APMs will be different from the AUCM depending on the specifics and needs of the targeted patient population.

Improving MIPS, APMs, and Increasing Participation in Value-Based Payment Models

Broadly, MACRA as implemented is a "one-size-fits-all" approach for physicians and other clinicians, regardless of specialty or practice model, thereby ignoring core differences between different modalities of care. A truly transformative, value-based payment system must recognize and be able to encompass different models of care:

- Non-episodic/scheduled care (primary care including chronic/longitudinal care management)
- Episodic/scheduled care (typically elective procedures, mostly specialty care)
- Episodic/unscheduled care (emergency care, urgent care

CMS tried to address this one-sized-fits-all constraint through the creation of the MIPS Value Pathways (MVPs). Under this optional approach, clinicians can report on a uniform set of measures on a particular episode or condition in order to get MIPS credit. ACEP developed an emergency medicine-focused MVP that CMS will be including in the first batch of MVPs starting in 2023. While we are excited about the implementation of this MVP, known as the Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP, we are generally concerned that not many clinicians will actually report through the MVP next year.

MVPs generally include the same sets of measures as traditional MIPS and have the same overall scoring rules. There are no additional financial incentives for participating in an MVP. Due to the COVID-19 public health emergency, hardship exemptions have been in place for the 2019, 2020, 2021, and 2022 MIPS performance periods. Therefore, for some clinicians, 2023 may be the first time they participate in MIPS in four years. These clinicians may not be willing to take a risk and try a new method for reporting in MIPS, especially when the potential downside is significant – a nine percent reduction in reimbursement on all Medicare covered professional services.

To help ensure MACRA's success, we ask Congress to consider refining MIPS overall, including the MVP approach established by CMS, in order to better tailor the program to the type of care a physician typically delivers. For example, there could be a system in which primary care continues to use traditional quality and cost measures, scheduled care could use episodes-of-care and MVP measures, and emergency care could use its own paradigm, relying on more relevant measures like the EM cost measure with a 14-day episode (as opposed to 30-day for other specialties). Such a system would better reflect the type of work a physician performs the majority of the time.

Further, the clinician community believed when MACRA was passed that the ultimate goal was for most clinicians to transition away from MIPS to participate in Advanced APMs. Besides there not being opportunities for most specialists to participate in Advanced APMs, there should also be better, and more sustainable incentives to participate in these models. To address these underlying issues, ACEP has developed recommendations to reconcile MIPS.

Recommended Changes to Streamline MIPS

MIPS Reporting Requirements

CMS has taken a number of efforts to try to streamline MIPS reporting. Under the MVP approach, there is a more limited set of measures within the Quality and Improvement Activities Performance Categories on which clinicians can report. Further, CMS has created the "facility-based scoring option" that has been effective since the 2019 performance year. With this scoring option, clinicians who deliver 75 percent or more of their Medicare Part B services in an inpatient hospital, on-campus outpatient hospital, or emergency room setting will automatically receive the quality and cost performance score for their hospital through the Hospital Value-based Purchasing (HVBP) Program. Most emergency physicians qualify for this option.

Despite these efforts, CMS still must work within the statutory constraints of the MIPS program, which require clinicians to meet standards under four separate performance categories. ACEP has long supported the concept of allowing clinicians to report on one set of measures and receive credit in multiple categories of MIPS, as it will help reduce the burden of reporting for physicians and also link elements of the program together into one cohesive function. ACEP also supports concepts like those within the draft legislation, "To amend title XVIII of the Social Security Act to allow for the use of alternative measures of performance under the Merit-based Incentive Payment System under the Medicare program" proposed by Representative Larry Bucshon (R-IN), because the increased flexibility of using facility-based measures will alleviate additional burden. We also believe that clinicians who use certified electronic health records (EHRs) to participate in a clinician-led qualified clinical data

registry (QCDR) should be qualified as fully achieving all points for the Promoting Interoperability category. In all, Congress should provide more flexibility to CMS to allow clinicians to receive full MIPS credit for reporting on certain measures or conducting certain improvement activities that are most relevant to their practice. As described earlier, emergency care is unique and requires its own paradigm in order to reflect the fact that it is episode-based, acute, and unscheduled. Emergency physicians, like other specialties, should have the flexibility to improve their overall cost and quality performance in a way that aligns with that paradigm.

Invest in Quality Measure Development

Over the last several years, CMS has reduced the number of available quality measures on which clinicians are able to report. Part of this trend is due to the increase in "topped out" measures. A measure can become "topped out" when most clinicians are performing extremely well on the measure and performance on the measure cannot be meaningfully improved. Topped out measures are being phased out of the program.

Given this movement to eliminate, not add, measures to the MIPS quality measure inventory, some specialists have a paucity of measures that are clinically relevant to their specialty on which they can report. Instead of CMS investing in the development of new quality measures, CMS relies on specialty societies to fund the development of measures. This is truly a costly endeavor, as it could cost anywhere from $250,000 to $1 million to develop and fully test a new quality measure. Additionally, ACEP supports concepts like those in the "Fewer Burdens for Better Care Act of 2023" from Representative Blake Moore (R-UT), which will provide stakeholders with a longer period of time to provide feedback on quality and efficiency measures that are considered for removal. Many specialty societies cannot afford to develop measures and therefore the number of reliable measures will continue to decrease. Congress should provide CMS with adequate funding to develop additional clinically-relevant and evidence-based measures that clinicians of all specialty types will find meaningful.

Reduce Reliance on Inaccurate Cost Measures

The Cost Category of MIPS represents 30 percent of the total MIPS performance score. However, as with quality measures, there is a lack of relevant cost measures for certain specialties. CMS currently employs a single contractor, Acumen LLC, to develop new episode-based cost measures. If specialists do not have an episode-based cost measure, they could be attributed to two program-wide cost measures: the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measure.

Some emergency physicians are attributed to the MSPB measure specifically. This measure captures the "cost of services performed by hospitals and other healthcare providers during the period immediately prior to, during, and following a beneficiary's hospital stay." It attributes all Medicare Part A and B costs occurring in the episode window to the clinician(s) responsible for care—which could end up indirectly being an emergency physician. ACEP believes this is unfair, as emergency physicians are generally not the physician driving the cost of care delivered during a hospital stay. Another issue is that this measure is truly a "black box" calculated by CMS using administrative data, and we have expressed concerns about the validity of the measure and its attribution methodology.

To help address the lack of emergency medicine-specific cost measures, CMS and their contractor, Acumen, convened an expert panel to develop a cost measure that could be directly attributable to emergency medicine clinicians. ACEP has helped lead the way in that process, with an ACEP member having the opportunity to chair the expert panel, and other ACEP members serving on the panel as well. Using the insights from the panel, Acumen constructed an EM cost measure, which was then adopted by CMS in the 2024 Physician Fee Schedule. The measure includes elements of ACEP's APM, the AUCM, and the emergency medicine MVP.

Since the development of meaningful cost measures is a lengthy process, and the currently available cost measures are not clinically relevant, ACEP recommends that Congress eliminate the statutorily-mandated 30 percent weight for the Cost Category, and provide CMS the discretion to set the Cost Performance Category at a lower weight.

Continue to Support Qualified Clinical Data Registries (QCDRs)

QCDRs are third-party intermediaries that help clinicians report under MIPS, and they have proven to be an excellent way to collect data and report quality measures. ACEP developed its own QCDR, the Clinical Emergency Data Registry (CEDR), offering 25 EM specific measures and 22 QPP measures spanning five domains of care.[4] QCDR measure owners invest significant resources into measure development, data collection, and validation. Additionally, QCDR measure owners develop

[4] https://www.acep.org/cedr/

these measures for use beyond MIPS reporting (e.g., research, guideline development, quality improvement, etc.). Section 1848(q)(5)(B)(ii)(I) of the Social Security Act, as added by Section 101 of MACRA requires HHS to encourage the use of QCDRs to report quality measures under MIPS. In line with this statutory requirement, ACEP has urged CMS to continue refining the QCDR option under MIPS to streamline the self-nomination process and provide better incentives for organizations, including medical associations such as ours, to continue to invest in their QCDRs and develop new, meaningful measures for specialists to use for MIPS reporting and other clinical and research purposes. Conversely, CMS should refrain from finalizing proposals that would impose significant and unreasonable burdens on QCDRs.

In general, ACEP believes that CMS should do more to promote the use of clinical data registries. A number of challenges and burdens limiting the uptake of QCDRs persist. For CEDR, the biggest challenge has been garnering the cooperation of hospitals on behalf of our clinician client base. Hospitals have no incentive to build or maintain data feeds to serve their contacted clinicians. In fact, a substantial number of emergency physicians that use CEDR to report quality measures are unable to receive any data from their hospitals. Without these data elements, the quality measures cannot be fully calculated and scored. Hospitals may claim that they cannot share the data for privacy and security purposes, but there are no regulations that impede hospitals from doing so. Thus, these hospital-based clinicians may also need to rely on the MIPS facility-based scoring option unless CMS takes more concrete going forward to help improve data exchange between hospital EHRs and registries – however, CMS decided to eliminate the facility-based scoring option under MIPS in 2022. In addition, hospitals often charge clinicians groups exorbitant fees to build these data feeds. We have urged CMS to consider requiring hospitals to share data with hospital-based clinician groups. Congress should consider legislation to create safe harbors and reduce other barriers to facilitate the transfer of data between hospitals and clinical data registries.

Further, as emergency physicians strive to provide high-quality, objective, and evidence-based medicine, we should ensure clinician-led registries have access to Medicare claims data. These data are critical in tracking patient outcomes over time, expanding the ability to assess the safety and effectiveness of care, and providing information necessary to assess the cost of delivered care. We urge Congress to consider H.R.5394, the Meaningful Access to Federal Health Plan Claims Data Act of 2021, to allow clinician-led clinical data registries to access to these data in the effort to ensure better patient outcomes and health care affordability.

Another major ongoing issue for specialists is not being able to report on measures that are meaningful to them. Emergency physicians have experienced this problem in the past, and that is specifically why ACEP developed CEDR. Through CEDR, ACEP reduces the burden for our members and makes MIPS reporting a meaningful experience for them. We strive to make reporting as integrated with our members' clinical workflow as possible and constantly work on improving their experiences and refining and updating our measures so that they find value in reporting them. We have found that if our members can report on measures that are truly clinically relevant, they become more engaged in the process of quality improvement. For each measure we develop, a Technical Expert Panel comprised of clinical, measurement, and informatics experts in the field of emergency medicine is assembled, and several criteria are considered when designing a measure, including each measure's impact on emergency medicine, as well as whether the measures are scientifically acceptable, actionable at the specified level of measurement, feasible, reliable, and valid. Through our work and partnership with CMS, we are proud to have been a certified QCDR and have helped tens of thousands of emergency physicians participate successfully in MIPS.

With respect to QCDR measure approval requirements, while testing measures and ensuring their validity is critical, we believe that the QCDR testing requirements are stringent, place a significant burden on QCDRs, and make it difficult for some smaller QCDRs to continue participating in the MIPS program. We also believe that, because the COVID-19 extreme and uncontrollable circumstances exception policy decreased the number of groups reporting to MIPS via QCDRs, CMS should only require face validity for the first two MIPS payment years for which the measures are approved or until two years after the end of the COVID-19 PHE, whichever is later. We also suggest that QCDR statisticians familiar with sample sizes and populations should decide the level of testing (clinician, facility, or group) required. We have further requested that CMS also delay the testing requirements for measures in MVPs. The development and testing process for measures is a lengthy and costly process and will inhibit the ability of new measures to be incorporated into MVPs.

Extend the $500 Million Exceptional Performance Bonus

ACEP opposes the application of budget neutrality in Medicare physician payment, including MIPS payment adjustments. Budget neutrality in MIPS means penalizing small and independent practices, as these practices tend to receive lower overall MIPS score and their penalties are used to fund incentives for large health systems that have the staff and technological resources

to manage, optimize, and report metrics to CMS. The continuation of the $500 million exceptional performance bonus is crucial to eliminating the need for budget neutrality within the MIPS program.

Provide CMS flexibility to set performance thresholds based on data

CMS proposes to increase the threshold that clinicians need to achieve in order to avoid a penalty to 82 points in 2024— seven points higher than the 2023 threshold of 75 points. By law, CMS has to set the performance threshold at the mean or median of a prior performance year, and they decided to pick the 2019 performance period when setting the 2024 performance threshold.

ACEP is strongly opposed to this proposal. This is the first year since the start of the COVID-19 PHE that the Extreme and Uncontrollable Circumstances Exception is unavailable, meaning that some clinicians may be reporting MIPS for the first time since 2019. Those who did choose to report the last few years were clinicians who were most likely to exceed in performance and therefore receive a bonus. Thus, the data were skewed, as those who did not anticipate a bonus opted not to submit data for MIPS reporting, creating artificially inflated benchmarks. Even the regulatory impact analysis in this rule estimates that the percentage of eligible clinicians who will receive a negative adjustment will increase from 36.75 percent to 54.31 percent. For small practices, this estimate is even higher, at a staggering 60.18 percent.

In order to reintegrate back into MIPS reporting, ACEP believes it is most appropriate to slowly increase the performance threshold over time. Raising the performance threshold too quickly, as is proposed, would penalize clinicians for not meeting a threshold that does not accurately represent the actual performance of the majority of MIPS eligible clinicians. It would also have a more detrimental impact on smaller physician practices and those located in rural areas, as these practices may not have the resources necessary to perform as well in MIPS. CMS must keep the threshold at 75 points in performance year 2024.

Recommended Changes to MVPs

To encourage participation in MVPs, ACEP recommends the following changes to the MVP structure:

Create More Incentives for Participating in MVPs

ACEP believes there should be additional incentives for initially participating in an MVP over traditional MIPS. Although we hope that participating in the emergency medicine MVP in 2023 will reduce administrative burden for emergency physicians and allow them to focus on specific quality measures and activities that improve the quality of care they deliver, we also think that many emergency physicians may be hesitant to make any changes to their reporting patterns. ACEP recommends that CMS include at least a five-point bonus for participating in an MVP initially. While we understand that CMS may receive pushback at a later date if and when the agency decides to eliminate such a bonus, we truly believe that an incentive is necessary to maximize participation in MVPs at the start.

In addition to establishing a participation incentive bonus, clinicians who participate in MVPs should also be held harmless from downside risk for at least the first two years of participation while they gain familiarity with reporting the defined measures within the MVP. While the scoring rules for MVPs are slightly more advantageous than they are for MIPS (for example, clinicians are only scored on four quality measures instead of six), they have fewer options overall and are not able to choose from a broad range of quality measures and improvement activities. Under traditional MIPS, clinicians report on as many quality measures as possible (10-15 measures), with the understanding that CMS will score the top six highest performing measures. If these clinicians were to report under the Adopting Best Practices and Promoting Patient Safety within the Emergency Medicine MVP, they would only be able to report up to nine measures and would be scored on the top four. Therefore, even though clinicians are scored on fewer measures if they choose to report under the MVP, the chances of them receiving high scores on their selected measures may actually be lower.

Eliminate the Foundational Layer

CMS should also eliminate the foundational layer of population-based measures included in each MVP. Overall, ACEP believes that measures included in MVPs should be those that have been developed by specialty societies to ensure they are meaningful to a physician's particular practice and patients, and measure things that are actually under the control of the physician. As hospital-based clinicians, we are concerned about the measure reliability and applicability, case size, attribution, risk adjustment, application at the clinician or group level, and degree of actionable feedback for improvements. Further, many of the existing population claims measures have not been tested at the physician level, are based on a retrospective analysis of claims, and do not provide sufficiently granular information for physicians to make improvements in practice. Physicians do not treat a defined population, but rather treat patients as individuals tailored to their specific needs.

Recommended Changes to Advanced APMs

Under MACRA, eligible clinicians who become Qualifying APM Participants (QPs) were eligible for a 5% APM Incentive Payment. However, after performance year 2022 (with a corresponding payment year of 2024), there was no further statutory authority for this bonus in MACRA. Congress extended the bonus for performance year 2023 (payment year 2025) in the CAA, 2023 at a lower rate of 3.5%. ACEP supports some proposals within the draft legislation "To amend title XVIII of the Social Security Act to extend incentive payments for participation in eligible alternative payment models" by Representative Neal Dunn (R-FL) to help extend the bonus to 2026.

Beginning in 2026, there is a separate conversion factor update for clinicians who participate in MIPS and those who are QPs. The conversion factor update for QPs is 0.75 percent, and the update for non-QP MIPS clinicians is 0.25 percent. After 2026, CMS believes that clinicians who participate in MIPS and receive a positive MIPS adjustment (in addition to the general 0.25 percent conversion factor adjustment they will receive) may actually receive a higher overall payment under the PFS than those who participate in Advanced APMs and only receive a 0.75 percent conversion factor increase.

We share CMS' concern that this may incentivize more clinicians to participate in MIPS than Advanced APMs, but reiterate that many specialists like emergency physicians simply have no opportunity to participate in Advanced APMs. This basic lack of fairness to specialists who had no reasonable chance to qualify for the now-expired five percent APM incentive payment once again highlights one of MACRA's key underlying flaws. Significant portions of the clinician workforce are precluded from collaborating in the transition to a value-based health care system. Congress should prioritize extending the five percent bonus for participation in Advanced APMs.

Additional Recommendation: Create Incentives to Reduce ED Boarding

ED "boarding," a scenario where patients are kept in the ED for extended periods of time even after admission to the hospital due to a lack of available inpatient beds or space in other facilities where they can be transferred, is a longstanding challenge for EDs but is now at crisis levels across the country, with many hospitals near or at their breaking point. Overcrowding and boarding are not failures of the ED; rather, they are symptoms of larger systemic issues that must be addressed to eliminate bottlenecks in health care delivery and reduce the burden on the already-strained health care safety net. While the causes of ED boarding are multifactorial, growing staffing shortages throughout the health care system have recently brought this issue to a critical point, and the resulting added stress and burnout are leading to an exodus of physicians and nurses – further exacerbating the crisis and spiraling the system towards a very real risk of collapse. As you know, these staffing shortages are also not limited to just the hospital setting, as EDs also feel the direct impact of staffing challenges in skilled nursing facilities (SNFs) and long-term care facilities (LTCFs). Additionally, psychiatric boarding issues worsen each day due to a severe lack of available psychiatric beds outside of acute care hospitals.

Efforts to address the pervasive issue of boarding are not only necessary to ensure the continued health and availability of the health care safety net but will also provide downstream benefits throughout the entire health care system. MIPS, MVPs, and APMs alike could all be improved by implementing incentives to reward hospitals and physicians for addressing boarding through safe discharge and coordination of post-discharge care. To improve quality and reduce costs, we urge Congress to consider these proposed enhancements:

- Focus on services provided to populations with moderately complex conditions and high ED visit rates;
- Center around the disposition to admission, observation care, or the home;
- Reward efficient treatment and effective post-acute care coordination;
- Harmonize with other value-based models to allow rapid adoption in organizations already engaged in APMs; and,
- Incorporate relevant quality measures, including those related to appropriate disposition and post-ED visit events (e.g., return to ED, readmission, and death).

Once again, we appreciate the Subcommittee's attention to this critical issue, and we are for the opportunity to share our experiences. Should you have any questions or require any further information, please do not hesitate to contact Ryan McBride, ACEP Congressional Affairs Director, at rmcbride@acep.org.

Sincerely,

Aisha T. Terry, MD, MPH, FACEP
ACEP President

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Re: "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

October 19, 2023

Division of Legislative Counsel 202-789-7426

STATEMENT

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Re: "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

October 19, 2023

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA works tirelessly to ensure health care access and coverage for Americans across the nation, especially for the country's most vulnerable patient populations. We appreciate the Committee's interest in examining the best pathway forward toward a Medicare physician payment system (MPS) that rewards clinicians who deliver high quality care and preserves access to Medicare beneficiaries moving into the future.

The cost of practicing medicine is rising at the fastest rate in decades, yet physicians face a confluence of Medicare payment cuts next year due to statutory budget neutrality requirements, expiration of temporary updates, and unfair penalties under the Merit-based Incentive Payment System (MIPS). Other time consuming and expensive administrative burdens are keeping physicians away from patient care and adding unnecessary costs to the health care system. The current physician payment system is on an unsustainable path that is jeopardizing patient access to physicians. We are burning physicians out at a time when an estimated 16,000 seniors a day are entering the Medicare system and there is a nationwide physician workforce shortage. Without systemic reforms, including annual inflation-based updates, the current Medicare physician payment system will continue to drive private practices out of business.

TO PRESERVE ACCESS TO CARE, PHYSICIANS NEED FISCAL STABILITY

Under current law and the proposed 2024 Medicare Physician Payment Schedule (MPS), the 2024 Medicare physician payment conversion factor would be reduced by 3.36 percent from 2023. This cut coincides with historic growth in the cost to practice medicine as the Centers for Medicare & Medicaid Services (CMS) projects the increase in the Medicare Economic Index, which is the federal government's measure of annual changes in physicians' operating costs, will be 4.5 percent in 2024.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. We already know how that story ends, and it is not a happy ending. According to the Medicare Trustees, if physician payment does not change, access to Medicare-participating physicians will become a significant

issue in the long term. Some Medicare patients are already experiencing inequitable delays in care, and we know that when care is delayed, health outcomes worsen. These problems particularly impact minoritized and marginalized patients[1] and those who live in rural areas.[2] Will patients with Medicare have to wait six months to see a neurologist when they can no longer remember what day of the week it is? Will they have to wait eight months for an appointment with an oncologist about a persistent lump? Will they forego an endoscopy or mammography because the nearest gastroenterologist or radiologist who accepts Medicare is more than an hour away? We are urging both Congress and CMS to intervene before these problems get any worse.

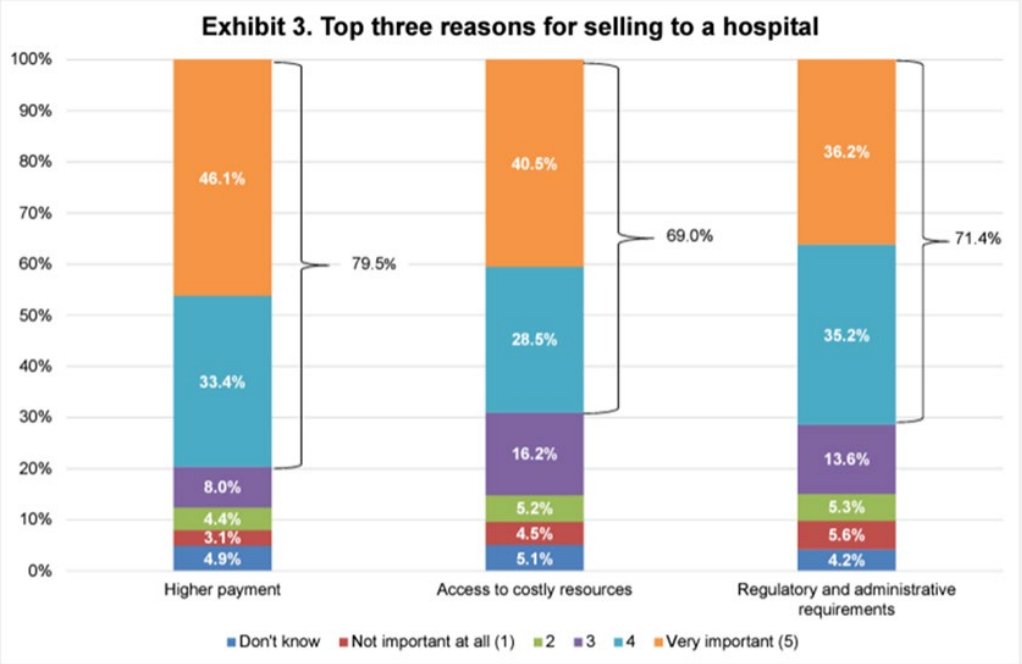
We appreciate that in the Consolidated Appropriations Act of 2023, Congress partially mitigated a 4.5 percent cut to Medicare physician payment rates, but physicians still endured a two percent pay cut this year and for 2024, physicians are facing another 3.36 percent cut, once again confronting the grim task of reconciling how to keep their lights on while getting paid less, while their expenses continue to rise. In fact, between 2001 and 2023, the cost of running a medical practice increased 47 percent, or 1.8 percent per year. In striking contrast, physician payment rates have increased just nine percent over the last 22 years, or 0.4 percent per year, according to data from the Medicare Trustees. Adjusted for inflation, Medicare physician payment rates declined 26 percent from 2001 to 2023, or by 1.3 percent per year.

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. The Biden Administration has recognized that health care consolidation is leaving many areas, particularly rural communities, with inadequate or more expensive health care options. As discussed in detail below, consolidation in the hospital market is also shown to increase health care costs and lead to worse outcomes.

A new AMA analysis 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. Included below is an excerpted figure with more detail. 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.

[1] See e.g., Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE. Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. *JAMA.* 2021;326(7):628–636. doi:10.1001/jama.2021.10413.

[2] https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf.



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

Earlier this year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase 2024 Medicare physician payments above current law by linking the payment update to the MEI, something the AMA and organized medicine have long supported. MedPAC raised concerns about the growing gap between what it costs to run a medical practice and what Medicare pays.

The AMA is strongly urging the Biden Administration to mitigate the reduction to the 2024 Medicare conversion factor; however, the reduction stems largely from the expiration of a temporary update and statutory budget neutrality requirements, which means physician payment will again be cut in 2024 unless Congress intervenes. The annual "stop the Medicare payment cut" exercises are due, in no small part, to the fact that physician services do not receive the annual inflationary update that virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. The COVID-19 pandemic further illustrated the challenges physicians endure due to the current broken Medicare payment system. While the temporary and partial patches that Congress has provided through 2024 were necessary under the current payment system, they 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.

We strongly support 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. At a minimum, Congress should end the freeze on Medicare physician payment updates under MACRA and provide a one-year update that reflects the increase in the MEI. This would serve as a down payment on long-term reforms.

PROVIDER REIMBURSEMENT STABILITY ACT OF 2023

Physician payments are further eroded by frequent and large payment redistributions caused by budget neutrality adjustments. The AMA strongly supports this draft legislation's provisions that offer practical policy improvements to provide some needed stability to the physician payment system by incorporating corrections from data collected during the look back period.

Reconciliation of Budget Neutrality

CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the payment schedule, resulting in permanent removal of billions of dollars from the payment pool. For example, a previous administration based the 2013 budget neutrality offset for Transitional Care Management (TCM) on a significantly greater estimate of initial utilization of the service than what actually occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after 3 years of implementation. For 2013, Medicare physician payment schedule spending was reduced by more than $700 million based on the overestimate of TCM utilization. Similarly, CMS overestimated Chronic Care Management (CCM) utilization when adopting that code one year later (4.7 million estimated claims versus 954,000 in the first year).

The overestimates of the utilization for TCM and CCM and the budget neutrality adjustments resulted in permanent reductions in MPS payments disadvantaging physicians. On the horizon, there is the potential for a further overestimate of utilization for an add-on code for "inherently complex" Evaluation and Management (E/M) services. While Congress passed a moratorium on implementation of this code until 2024, CMS believes this service will be billed 38 percent of the time when billable. This assumption is highly speculative given CMS' past overestimates of TCM and CCM utilization.

Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS the flexibility to account for past overestimates of spending when applying budget neutrality. **We strongly urge Congress to require a look-back period (as have been implemented in other payment systems) that would allow CMS to correct for overestimates and return inappropriately reduced funding back to the payment pool.**

Raising the $20 million Budget Neutrality Threshold

The budget neutrality threshold is a level of estimated program spending changes that triggers a budget neutrality adjustment under the MPS. The threshold is designed to ensure that changes to the MPS do not increase Medicare spending. Historically, the threshold was set at $20 million, a figure established in 1989—three years prior to the official rollout of the MPS. This value was initially conceived to determine if RVU modifications would necessitate budget neutrality adjustments. However, this threshold has remained stagnant, with no updates to account for the inevitable changes in economic conditions and inflation over the years.

Increasing the budget neutrality threshold is essential to ensuring that the MPS remains fair and equitable for physicians. The threshold no longer effectively captures the true financial dynamics of healthcare and makes it difficult for Medicare payments to keep up with new medical technologies and services. This can lead to physicians being underpaid for the services they provide, which can have a negative impact on patient care. **We strongly urge Congress to increase the amount to $53 million to best account for past inflation and update the threshold every five years by the cumulative increase in MEI since the last update to the threshold.**

In addition, to help to ensure that the threshold remains at a reasonable level and does not become a barrier to fair Medicare payments, the threshold should be increased every five years based on the cumulative rate of inflation tied to MEI. This would help to ensure that the threshold remains at a reasonable level in the future.

Updating Prices for Direct Expenses for Budget Neutrality Adjustments

The current MPS methodology for calculating practice expense RVUs is based on direct costs incurred by physicians in providing services, such as clinical staff wage rates, prices of medical supplies, and prices of equipment. If the RVUs are not based on timely and accurate data, physicians may not be adequately reimbursed for their costs, which could lead to financial hardship for their practices and reduced access to care for patients.

Congress should require CMS to update the wage rates for clinical labor, the prices of equipment, and the prices of medical supplies simultaneously at least once every five years. A long lag between updates and the fact that they have been done in different years has made the changes more disruptive than necessary for physicians. For example, in 2019, when CMS finally updated supply and equipment prices, there were significant increases in the prices of some commonly used items. This led to financial hardship for some physicians who do not use these supplies and equipment, and so were not expecting the resulting large budget neutrality adjustment to their payments. Requiring CMS to update the prices of medical supplies more frequently would help to ensure that the MPS more accurately reimburses physicians for their costs. Also, conducting labor and supply updates at the same time and more frequently will reduce the amount of redistribution that is necessary to keep the MPS balanced.

RECOMMENDATIONS TO SALVAGE THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

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 legacy programs: Meaningful Use, Physician Quality Payment System (PQRS), and Value-Based Payment Modifier programs. Throughout the years, the AMA has offered a steady series of constructive recommendations to improve MIPS. As part of our commitment to better enable a well-designed program, we also sought to address the existing gap in quality measures by developing a set of quality measures that would serve as a means of assessing and incentivizing high-quality diabetes preventive care and align with our diabetes prevention work. Unfortunately, the AMA's experience with this process is an excellent example of the many challenges physicians have with MIPS. In addition, for a variety of reasons, CMS has not adopted many of our recommendations to improve the program. Consequently, 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. The AMA had anticipated when MACRA passed that by the time physicians would be subject to significant penalties from MIPS, the challenges with the program would be minimal and there would be many Alternative Payment Models (APMs) for all specialties to participate in. Unfortunately, that is not the case.

In its current form, MIPS is a repackaging of legacy programs, including PQRS. CMS will highlight its efforts to change the program via the new MIPS Value Pathways (MVPs), but MVPs retain the same core rules and requirements of MIPS, despite physicians' recommendations for improvements and early participation in the development of MVPs. By carrying the flawed MIPS policies over into MVPs, CMS is doing the same thing and expecting a different result.

Therefore, 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. The AMA is strongly recommending that Congress make three key changes to MIPS to remedy these problems.

Background

CMS applied automatic MIPS hardship exceptions due to the COVID-19 pandemic in 2019, 2020, and 2021, and accepted applications for COVID-19 hardship exceptions in 2022 and 2023. While we supported these much-needed flexibilities, the program was severely disrupted for five years due to unforeseeable circumstances and, as a result, the gradual implementation of MIPS as originally envisioned by Congress in 2015 under MACRA was not realized. Meanwhile, CMS continues to rachet up the requirements.

As MIPS requirements have continued to increase each year and the penalties (now at nine percent) apply in full, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2024 Medicare Physician Payment Schedule proposed rule, CMS estimates that over half (54 percent) of eligible clinicians (ECs) will receive a MIPS penalty averaging -2.4 percent in 2026. This is in large part due to the proposed increase to the number of points needed to avoid a MIPS penalty in 2024 (the number of points needed now stands at 82 points compared to just 15 points in 2018, the last year that MIPS was fully in effect before the COVID-19 automatic hardship exceptions took effect). Even more alarming, CMS estimates that nearly 65 percent of ECs in solo practices and 60 percent of ECs in small practices would receive a penalty, confirming that this program is penalizing small practices and redistributing those funds to large, well-resourced health systems. To be clear, there is no reason to believe that the disproportionately negative impact on small, rural, and safety net practices is due to differences in the quality or cost of care provided to Medicare beneficiaries. Rather, this discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources.

Additionally, we are hearing alarming reports that physicians are receiving penalties in 2024 for the first time in the program, which will compound the proposed -3.36 percent reduction to the conversion factor. We have serious concerns that a lack of awareness of the expiration of the automatic COVID-19 flexibilities unfairly penalizes physician practices and disproportionately impacts small, independent, and rural practices. Even practices that were historically successful in the program are now expected to receive a penalty in 2024 due to the Cost Category being weighted at 30 percent of MIPS final scores for the first time as the cost measures were not even calculated in the two prior performance years due to COVID-19. Furthermore, there were errors in CMS' coding and measure specifications in the Cost Category that we anticipate will contribute to the number of physicians who will receive penalties. Also, physicians had no way to anticipate, monitor, or improve their 2022 cost performance category score because CMS did not share any data about attributed measures, patients, or observed costs until August 2023—more than eight months after the conclusion of the performance period.

As a possible solution to lessen the 2024 payment cuts, the AMA strongly urged CMS to extend the October 9, 2023, deadline to appeal a MIPS payment penalty and to permit physicians to apply for a COVID-19 hardship exception as part of their Targeted Review request. There is CMS precedent to utilize the Targeted Review process to claim extreme and uncontrollable circumstance (EUC) due to the PHE. Prior to CMS automatically applying the EUC to 2019 performance/2021 payment adjustments, CMS allowed practices to file a 2020 Targeted Review and claim the PHE. Unfortunately, CMS held

strong to their deadline and ignored our plea and potential solution.

In addition to the concerns about the significant increases in MIPS penalties starting in 2024, there is mounting evidence that the program as currently implemented is causing significant administrative burden, raising costs for physician practices, and disadvantaging small, independent, and rural practices, all with no proven improvement on quality outcomes. This discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources. In a 2019-2020 survey, physician practice leaders from a variety of specialties, practice types and locations reported that MIPS caused substantial administrative burden. Key contributing factors cited were constant programmatic changes, data collection and reporting, and interference with patient care. In fact, the program may be exacerbating health inequities by negatively impacting practices that serve medically underserved populations.

In summary:

- **MIPS disadvantages rural and medically underserved populations.** According to the U.S. Government Accountability Office (GAO), practices serving rural and medically underserved patient populations face numerous challenges participating in MIPS, including lack of technology vendor support, high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of changing program requirements. According to another GAO report, similar challenges limit rural practices' abilities to transition to APMs.

- **MIPS does not correlate with improved quality of care.** A 2022 study in *JAMA* found that MIPS may not even correlate with the quality of care delivered and that physicians caring for more medically or socially vulnerable patients were more likely to receive low scores despite providing high-quality care.

- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. The researchers found that the majority of the MIPS activities included reviewing medical records, collecting information from patients, and entering data into the electronic health record.

- **MIPS disadvantages small and independent practices.** Based on our analysis of 2021 MIPS performance data, three times as many clinicians in small practices had MIPS scores resulting in penalties—11.9 percent versus 3.36 percent overall. Further, according to a study in *JAMA*, affiliation with a health system was associated with significantly better 2019 MIPS performance scores.

- **MIPS disadvantages safety net practices and exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.

Furthermore, following an in-depth analysis of the 2021 Quality Payment Program (QPP) Provider Data Catalog, we have found that the files are incomplete and inconsistent and, as a result, it is difficult to drill down in the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case. Ensuring this data is accurate is critically important to ongoing efforts to understand and improve this program, which should be a shared goal of physicians, CMS, and MedPAC.

Specifically, there is one file that contains the MIPS scores for each clinician but does not have any information about the clinician other than their name and national provider identifier (NPI). The National Downloadable File that accompanies this MIPS score file has information about clinicians, such as their specialties and the names of the group or groups with which they practice. However, we have found that there are almost 100,000 NPIs with a MIPS score that are not included in the National Downloadable File. We looked at the 2020 files, and the same problem exists there. In 2020, there were 180,000 NPIs that have a MIPS score that are not in the National Downloadable File. When we looked in the CMS Enrollment File data for that same time period, there were several thousand NPIs with MIPS scores that were not in the Enrollment File. We are strongly urging CMS to explain and correct these inconsistencies between data files, particularly regarding why so many NPIs are missing from the National Downloadable File, and to instruct physicians how to otherwise access this important data.

Finally, there are mounting problems with the MIPS cost measures. First, we are concerned that CMS did not use the most updated Current Procedural Terminology® (CPT®) codes for its Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measure specifications in 2022 and 2023. The AMA reviewed the coding specifications currently posted to the Quality Payment Program website for 2023 and found that the coding specifications for the TPCC and MSPB have not been updated since 2020. The Evaluation and Management (E/M) section of the CPT code set underwent a major update in 2021, resulting in significant changes to the Office & Other Outpatient visit codes. In 2023, other code sets were updated, including the Inpatient & Observation codes, Nursing Facility codes, and Emergency Medicine codes, to name a few. These changes are on top of the usual yearly addition/revision/deletion of codes throughout the set. The CMS MIPS CPT coding specifications for TPCC and MSPB do not align with the CPT codes for the 2022 performance period or the current year (2023).

Additionally, our review of the CPT codes in the Surgical Attribution tab of the MSBP measure identified potential flaws in the coding for the surgical attribution methodology. For example, for a patient admitted to the hospital under the surgical diagnosis-related group (DRG) 040 (Peripheral/Cranial Nerve & Other Nervous System Procedures), it would be expected that a specific neurological procedure as listed in the Medicare Severity-Diagnosis Related Group (MS-DRG) specification was performed. However, in the CPT code mapping, there are many CPT procedure codes listed, such as CPT code 49561 (Repair of trapped incisional or abdominal hernia), that do not correspond to the principal procedures that are associated with the MS-DRG specified. In the case of MS-DRG 040, principal procedures would relate to operating room procedures such as nerve excisions, divisions, extirpations of matter, extractions, releases, and repairs. Selecting inpatient encounters based on the criteria as currently represented would not yield a sensible set of encounters suitable for quality comparisons. **We believe the out-of-date coding in the cost measure specifications will further exacerbate the number of physicians who receive penalties. Consequently, the AMA is recommending that CMS zero out the Cost Performance Category for 2022 and 2023, like it did in 2020 and 2021.**

Furthermore, the AMA is hearing reports that the cost measures are not functioning as intended. We are concerned by reports that group practices are being measured on the TPCC measure despite being excluded from the measure due to Qualified Health Professionals (QHPs) in their group practice billing Medicare directly. Similarly, we heard from hospital based QHPs that they were scored on TPCC despite the inpatient E/M codes being excluded from the measure specifications. We have heard from an internal medicine physician who scored very poorly on the Asthma/COPD cost measure despite performing well on the TPCC measure. It appears that one of the 20 patients attributed to the Asthma/COPD measure had sepsis during the performance period, which had an outsized impact on the physician's score and which was entirely outside the control of the physician.

Ophthalmologists are being scored on the Diabetes cost measure despite not managing their patients'

diabetes or prescribing the medications necessary to control the condition. While CMS agreed to remedy this attribution problem for 2023 and going forward, the agency has not budged on a solution for 2022, leaving ophthalmologists subject to unfair penalties based on performance on a cost measure for a condition they do not manage. We have heard that rheumatology practices are performing poorly on the TPCC measure, likely due to high Part B drug costs. A recent study[3] published in *JCO Oncology Practice* found that oncologists scored poorly on cost measures compared with other specialties in 2018 when the Cost Performance Category made up a relatively small portion of the overall MIPS score. Based on this study and what we are hearing from physicians, the AMA is concerned that neither the TPCC nor the MSPB measures fully account for the variation in costs in the standard-of-care medicine by specialty and that CMS is conducting an apples-to-oranges comparison.

When taken together, these reports raise serious doubts about whether the MIPS cost measures are fairly and accurately assessing variations in costs within the control of MIPS eligible clinicians as intended. We recommend that CMS study and re-evaluate the overall Cost category and the associated measures because it appears that the measures and underlying methodologies are resulting in major unintended consequences that will negatively impact physicians' payment for services provided to Medicare beneficiaries next year and not working as envisioned by Congress. **We strongly urged CMS to reweight this category and correct these problems before they negatively impact payment and patient access to care.**

Lastly, the AMA has tremendous concerns with CMS' process for reviewing and selecting measures for MIPS. The AMA has been a recognized leader in diabetes prevention for the past 10 years and has a long history as a measure developer. Yet, we spent six years and nearly $1 million on developing diabetes screening measures which CMS ultimately twice rejected with little to no explanation. The AMA approached this work holistically as the measures not only satisfy the needs of MIPS but support our larger quality improvement work in which we engage with physician practices and states throughout the country. Furthermore, the measures also align with CMS' focus on chronic conditions, as well as the efforts of the Centers for Disease Control and Prevention who have been a partner with us on all our diabetes work, including the development of these measures.

There are significant problems with a program that requires measure developers to spend extreme amounts of money without any indication (or contradictory indications) that the measures developed will be adopted. The AMA is more resourced than other physician organizations, but it is difficult to justify the investment to continue submitting measures to CMS. Key to achieving MACRA legislation's goals is the availability of an adequate portfolio of appropriate quality measures that is harmonized with improvement to assist physicians with advancing the care of their patients.

The AMA is aware that a number of specialties have had similar problems and, consequently, there are significant flaws in the process that must be addressed. CMS must move to a participatory measure consideration process to better ensure that physicians will find quality measures to use within MIPS and APM that are clinically relevant and meaningful for their practices and settings of care, as well as administratively actionable and useful in providing better care and value for patients. **We urge CMS to evaluate its process for incorporating measures into MIPS and APMs.**

We believe this litany of problems is a wakeup call for all policymakers regarding the serious negative unintended consequences of MIPS, particularly on the heels of the COVID-19 pandemic.

[3] DOI: 10.1200/OP.22.00858 JCO Oncology Practice 19, no. 7 (July 01, 2023) 473-483.

Recommendations

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; help practices transition to value-based care; and increase transparency and oversight in the program. Below we offer three legislative changes that would help to streamline and improve the program, drive quality improvements, and reduce negative impacts on small, rural, and safety net practices, all while reducing unnecessary burden on physician practices.

1. **Congress should mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, independent practices and practices that care for the underserved and allow practices to revitalize quality improvement infrastructures.**

To accomplish this aim, the MACRA statute should be amended to:

- Freeze the MIPS performance threshold for three years to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and transition back to MIPS following a five-year interruption due to COVID-19. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program. Congress should use the 2021 performance threshold of 60 points (out of 100), which CMS established as a transitionary policy to encourage participation on all MIPS measures.

- Eliminate MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to an annual inflation-based payment update (e.g., tied to the Medicare Economic Index (MEI)). Specifically, physicians could be subject to up to a one-quarter reduction in their update based on their MIPS performance, which would be consistent with the Hospital Inpatient Quality Reporting Program.

- Reinvest money from penalties both in bonuses for high performers, as well as investments aimed at assisting under-resourced practices with their value-based care transformation, with an emphasis on small practices, rural practices, and practices that care for underserved patients.

2. **Congress should hold CMS accountable for timely and actionable MIPS and claims data.**

Congress recognized the importance of timely data to drive performance improvement, which is why it originally mandated under MACRA that CMS must provide timely (i.e., quarterly) MIPS quality and resource use feedback, as well as claims data to physician practices, similar to the types of data provided to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).[4] Despite this requirement, physicians did not receive their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports are just high-level summary reports.

While CMS also produces an overall program QPP Experience Report, it too is of limited use. For example, the same physician can be counted multiple times if they bill for services through multiple organizations. And a physician can have a low MIPS score for one practice and a high MIPS score for another. On top of that, CMS does not break down performance by physician specialty, site of service, or the type of reporting. The report also fails to show any longitudinal trends about whether quality or cost are getting better or worse, nor does it provide a complete picture of what made a physician or group

[4] 1§42 USC 1395w-4(q)(12).

practice successful in MIPS. The AMA's own analysis of several MIPS data files found that they are incomplete and inconsistent. As a result, it is difficult to drill down into the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case.

No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. This means that physicians do not know in real time or even on a quarterly basis which cost measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs. Furthermore, an in-depth analysis of 2021 MIPS performance data also revealed concerning data inconsistencies too extensive to elaborate on here.

Accordingly, the AMA urges Congress to exempt from penalties any ECs who do not receive at least three quarterly MIPS feedback and claims data reports during the performance period.

3. Congress should make MIPS more clinically relevant while reducing burden.

As discussed above, MIPS is unduly burdensome and has not been shown to improve clinical outcomes or reduce unnecessary costs. Moreover, the program does not prepare physicians to move to APMs.

Therefore, we recommend that Congress amend the statute to solve these problems by:

- Removing siloes between the four MIPS performance categories to allow for multi-category credit, therefore reducing burden.

- Bringing MIPS into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.

- Recognizing the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. The attestation of using CEHRT is consistent with the hospitals' requirements in Promoting Interoperability, as well as current APM requirements.

- Enhancing measurement accuracy and clinical relevance, particularly within the cost performance category, to target variability that is within the physician's ability to influence.

- Aligning cost and quality goals. MIPS rarely evaluates quality and cost on the same patients and for the same conditions, which has been a key factor inhibiting its ability to drive clinical improvement. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. Harmonizing these measures would ensure MIPS is driving high-value care as intended while reducing burden on physician practices.

- Improving quality measurement accuracy by awarding credit for testing new or significantly revised measures, including Qualified Clinical Data Registry measures, for up to three years.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS; provide a bridge to transition to APMs; and promote the intended goals of MACRA

to leverage health information technology, improve quality, and reduce Medicare costs while reducing burden on physician practices more effectively. **Notably, none of these recommendations are expected to score.** We welcome the opportunity to discuss these recommendations in greater detail.

ALTERNATIVE PAYMENT MODELS

Advancing the movement to value-based care in Medicare by implementing APMs for physician services was an important goal of MACRA. Value-based care links payments for services provided to patients to the results that are delivered, such as the quality, equity, and cost of care. APMs are a key approach to achieving 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. There are various types of APMs, including accountable care organizations (ACOs), bundled payment models, primary care medical homes, and others.

The creation of the Center for Medicare & Medicaid Innovation (CMMI) and the Medicare Shared Savings Program (MSSP) aimed to provide a significant boost to Medicare APMs. CMMI was established to test new APMs and the MSSP allowed for the development of Medicare ACOs in which medical practices and hospitals or health systems work together to coordinate all care for a defined patient population. When Congress enacted MACRA in 2015, there were still too few APMs for physician services available, so Congress included an APM pathway and six years of incentive payments. Congress also recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA included the Physician-focused Payment Model Advisory Committee (PTAC) to review and recommend stakeholder-designed APM proposals.

Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. While the goal was to provide opportunities for the majority of physicians to transition into APMs, CMMI models implemented to date often have steep financial risk requirements, lack funding needed to successfully redesign care delivery, and are usually only available in selected regions. In addition, because these APMs must demonstrate savings for Medicare within a short timeframe, they are often terminated instead of being improved and expanded nationwide. In a report on practices in rural or underserved areas, the Government Accountability Office noted that many lack the capital to finance the upfront costs of transitioning to an APM and face challenges acquiring or conducting data analysis necessary for participation. Although the newest primary care medical home model in Medicare, called Making Care Primary, has many promising features, there is also no nationwide primary care medical home model in Medicare, so patients are not benefiting from the improvements in preventive care, health care quality, and management of chronic conditions that medical homes can provide.

A great source of frustration to the physician community is that, despite the many stakeholder-developed APMs recommended by the PTAC for testing or implementation, no Medicare APMs have been adopted from the PTAC proposals or developed by CMMI to help specialists improve care for patients with chronic diseases like rheumatoid arthritis, heart failure, chronic obstructive pulmonary disease, or inflammatory bowel disease, or patients who would benefit from innovations in surgical care. Instead of keeping patients healthier and preventing hospitalizations, the CMMI-developed APMs have largely focused on services provided to patients after they have already been admitted to the hospital or begun treatment such as chemotherapy. As a consequence, Medicare patients, especially those outside of the hospital setting, are missing out on the benefits of APMs, including more timely and accurate diagnosis, improved patient-physician shared decision making about treatment plans, preoperative rehabilitation, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

CMMI needs to update its criteria for adopting and expanding Medicare APMs. For example, requiring APMs

to achieve Medicare savings within a very short time span has led multiple medical home and other models to be terminated and limited adoption of specialty models. Meaningful pathways are needed for APM proposals developed by stakeholders, including those recommended by the PTAC, to be implemented in Medicare.

One result of the paucity of APMs for people with Medicare that reflects the experience of frontline practicing physicians has been that the APM incentive payments provided under MACRA to support physicians transitioning to APMs have reached far fewer physicians than had been forecast. In addition, MACRA requires sharp increases in the threshold percentages of APM participation for physicians to qualify for the APM incentive payments, but most APM participants cannot attain the higher thresholds.

Legislation Needed

It is clear that significant changes are needed to realize the robust pathway to APMs that Congress envisioned. Passage of the Value in Health Care (VALUE) Act, H.R. 5013, would be an important step forward in continuing to support the movement to value-based care. Specifically, Congress needs to:

- Reauthorize crucial incentive payments to increase physician participation in Advanced APMs before they expire at the end of 2023.
- Make revenue thresholds that participants need to meet to even qualify for the incentive payments more flexible and realistic, thus preventing abrupt increases schedules to take effect in 2024.

With strong support from the AMA and other key physician stakeholders, a bipartisan group of legislators has introduced this bipartisan legislation to extend the original five percent APM incentive payments included in MACRA and make further improvements to encourage increased APM development and physician participation. The AMA applauded the bill's introduction by Reps. Darin LaHood (R-IL), Suzan DelBene (D-WA), Brad Wenstrup (R-Ohio), Earl Blumenauer (D-OR), Larry Bucshon, MD (R-IN), and Kim Schrier, MD (D-WA). Since this bill falls in the Energy and Commerce Committee's jurisdiction, the AMA urges adoption of H.R. 5013, in full. At the very least, we respectfully request the Energy and Commerce Committee and Congress, as a whole, to pass Section 3 of the Value in Health Care Act. This particular section of the legislation would extend the traditional five percent Advanced APM incentive payments for two years, as well as freeze the revenue thresholds that participants need to meet to even qualify for the bonuses at 50 percent through 2025, thus preventing them from increasing to a near impossible to reach 75 percent in 2024. This section of the legislation also gives the Secretary of Health and Human Services (HHS) the authority to annually increase the revenue threshold but by no more than five percent in a given year, thus allowing for the steady progress towards value-based care to continue at a more reasonable pace.

While we applaud the House Energy and Commerce Committee for releasing a discussion draft bill focused on extending the Advanced APM incentive payments and freezing the revenue thresholds, the AMA has concerns with certain aspects of this legislative approach. First and foremost, the AMA's preference is for the Committee to provide the traditional five percent APM incentive payments for at least up to two years. We also urge the legislation to include provisions freezing the revenue thresholds that need to be met to qualify for the bonuses for 24 months. Most importantly, we urge Energy and Commerce to remove the section of the discussion draft that would cap the receipt of any future incentive payments for qualifying participants that have received these bonuses for more than four years. Placing a five-year cap on the receipt of Advanced APM incentive payments would essentially render any APM entity that participated in the program starting in 2020 from receiving these incentives moving forward. In addition, there is a lack of clarity surrounding the operational aspects of implementing this cap, including whether the four years needs to, in fact, be consecutive. The AMA believes it is unwise to try and enact

such a drastic, retroactive change to the Advanced APM program via a bill that is largely designed to ensure crucial incentive payments are temporarily extended and could have the unintended impact of stifling greater movement towards value-based care models.

PRIOR AUTHORIZATION/MEDICARE ADVANTAGE PLANS

Prior authorization, or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment remains a principal frustration for physicians and jeopardizes patient care. According to a 2022 AMA survey, physicians complete an average of 45 prior authorizations per week, an administrative burden that consumes nearly two business days of physician and staff time.[5] The burden has become so acute that 35 percent of physician survey respondents hired staff to work exclusively on prior authorization requirements and 88 percent of respondents described this burden as either "high" or "extremely high."[6] These results came from a survey of 1,001 physicians practicing in the United States who provide at least 20 hours of patient care per week and complete prior authorizations during a typical week.[7]

While this utilization management technique is overused, costly, opaque, and burdensome to physicians, it is also harmful to patients due to the fact that it delays patient care. In fact, 33 percent of physicians who participated in the 2022 AMA survey reported that prior authorization led to a serious adverse event, such as hospitalization, disability, permanent bodily damage, or even death, for a patient in their care.[8]

In addition, research from the federal government demonstrates that prior authorization leads to delays in patient care and inappropriate denials of medically necessary services. A 2018 report from the HHS Office of Inspector General (OIG) concluded that, between 2014 and 2016, MA plans overturned 75 percent of their own prior authorization and payment denials when appealed by providers and beneficiaries.[9] An April 2022 HHS OIG report also found that 13 percent of prior authorization requests denied by MA plans met Medicare coverage rules and 18 percent of payment request denials met Medicare and MA billing rules.[10]

As a result, the AMA remains a strong supporter of the "Improving Seniors' Timely Access to Care Act." While this bill passed the House of Representatives in 2021 during the 117th Congress and the Ways and Means Committee passed this legislation as part of H.R. 4822, the "Health Care Price Transparency Act of 2023," we applaud the House Energy and Commerce Committee for reviewing this bill as part of the legislative hearing. Introduced by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN), at its core, the "Improving Seniors' Timely Access to Care Act" seeks to simplify, streamline, and standardize the prior authorization process within Medicare Advantage. More specifically, the bill mandates that MA plans implement electronic prior authorization programs that adhere to new standards adopted by the federal government. This will help ensure that physicians are no longer forced to resort to faxes and e-forms, or even disparate, proprietary portals that fail to comply with these newly developed standards. In addition, the bill's provisions requiring robust data reporting, such as the number and percentage of prior authorization requests approved, denied, or approved upon appeal, will bring much needed transparency to ensure MA prior authorization programs are not inappropriately denying medically necessary care to patients and overburdening physicians with unnecessary requirements.

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[5] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.
[10] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

The AMA also remains supportive of the section of the legislation mandating MA plans issue faster prior authorization decisions as it will help improve patient health care outcomes and better stewardship of scarce Medicare resources. The requirements for health plans to provide real-time prior authorization decisions for routinely approved services, as defined in implementing regulations, will help ensure that patients receive the care they need without delay. We also support that the bill directs MA plans unable to meet the real-time processing requirement in the event of "extenuating circumstances" to issue final prior authorization decisions within a 72-hour and 24-hour timeline for regular and emergent services, respectively. Notably, the legislation requires MA plans to report the number of prior authorizations subject to this exception, providing the transparency needed to deter abuse of this provision.

Furthermore, we support the section of the legislation requiring more timely prior authorization decisions for all other services within Medicare Part C. Requiring MA plans to issue final decisions within 24 hours for emergent services and no later than seven days after receipt of regular prior authorization requests is a vast improvement over current MA program practices.

Last Congress, a flawed $16 billion Congressional Budget Office (CBO) score prevented the legislation from receiving Senate consideration and ultimately being passed into law.[11] The House Energy and Commerce Committee's consideration of this legislation in the 118th Congress brings us one step closer to enacting this bill legislatively.

It is important to note that many of the same reforms that were included in the "Improving Seniors' Timely Access to Care Act" are also under consideration in an electronic prior authorization proposed regulation that was released in December 2022 by CMS.[12] This comment period for the proposed rule closed in March 2023 and physicians are still awaiting the release of the final regulation. If the final prior authorization regulation includes a mechanism for issuing real-time decisions, requirements to complete emergency requests within 24 hours, and detailed transparency metrics, these policies must, in turn, be incorporated into CBO's baseline estimate for the legislation. In other words, incorporation of these policies could potentially lead to the $16 billion cost estimate being substantially lowered.

Thankfully, Congress is on record in support of the Biden Administration finalizing the regulation in a manner that mirrors the pending legislation. In June 2023, Senators Sherrod Brown (D-OH), Roger Marshall, MD (R-KS), Kyrsten Sinema (I-AZ), and John Thune (R-SD), as well as Representatives DelBene, Kelly, Bera, and Bucshon led a letter to HHS and CMS pushing for the pending electronic prior authorization regulation to include these three crucial policies found in the "Improving Seniors' Timely Access to Care Act."[13] The letter, which was ultimately cosigned by 61 Senators and 233 members of Congress, requests a final regulation to include: 1) a mechanism for real-time electronic prior authorization decisions for routinely approved items and services; 2) requirements that plans respond to prior authorization requests within 24 hours for urgently needed care; and 3) detailed transparency metrics. Even if the regulation is ultimately finalized with these three policies, we applaud Energy and Commerce for considering this legislation as it will codify these concepts into law. Enactment of this legislation will undoubtedly help mitigate some of the negative effects of prior authorization.

While the "Improving Seniors' Timely Access to Care Act" focuses on improving the processes pertaining to prior authorization, other bills that are more centrally focused on limiting the use of this

[11] https://www.cbo.gov/system/files/2022-09/hr3173_0.pdf.
[12] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient protection-and-affordable-care-act-advancing-interoperability.
[13] https://www.brown.senate.gov/imo/media/doc/senate_ma_pa_letter_to_cms_62123finalmerged.pdf.

utilization management technique should also be expeditiously considered by Congress. For example, the AMA supports H.R. 4968, the "Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act of 2023."

Introduced by Representatives Michael Burgess, MD (R-TX) and Vicente Gonzalez (D-TX) and referred to the House Energy and Commerce Committee, this bill amends the Social Security Act to exempt qualifying physicians from prior authorization requirements imposed by MA plans. The GOLD CARD Act of 2023 would exempt physicians from MA plan precertification requirements so long as 90 percent of the physicians' prior authorization requests were approved in the preceding twelve months. Services that are initially denied and pending appeal for at least 30-days are required to be considered approved with respect to the 90 percent threshold. The gold cards issued by MA plans would be applicable only to items and services (excluding pharmaceuticals) and remain in effect for at least one year. Although permitted to rescind the exemption, MA plans must demonstrate that less than 90 percent of the claims submitted during a 90-day plan period would not have received prior authorization. This 90-day lookback period must be extended until at least 10 claims are ultimately provided. In addition, the threshold also excludes any service that receives a change in coverage determination mid-year from the 90-day lookback period.

Finally, the legislation sets up a process that protects physicians from inappropriate rescissions of the gold cards. MA plan physicians who review the potential gold card rescissions are required to be actively engaged in the practice of medicine in the same or similar specialty as the physician under review, have knowledge about the specific service in question, and possess a current, nonrestricted license in the same state as the furnishing physician. Plus, physicians can appeal any attempt to rescind the exemption.

We urge the Energy and Commerce Committee to review and pass this legislation as soon as possible. Advancing the Improving Seniors' Timely Access to Care Act and the GOLD CARD Act will play a tremendous role in reducing the overarching burden of prior authorization on America's physicians.

PAYMENT DIFFERENTIALS BETWEEN HOSPITAL OUTPATIENT DEPARTMENTS AND PHYSICIAN PRATICES STEM FROM INADEQUATE MEDICARE PHYSICIAN PAY

Patients receive outpatient medical services in a variety of settings, including physician offices, hospital outpatient departments (HOPD) and ambulatory surgical centers (ASCs). With some exceptions, payment rates for outpatient services furnished in hospital facilities are higher than rates paid to physician offices or ASCs for providing the same service. The scope of the payment differential varies, depending on the service or procedure.

Payment differentials between HOPDs and independent physician practices stem from several factors, but most notably from inadequate Medicare physician payment rates. As mentioned above, Medicare physician pay has barely budged over the last two decades, increasing just 9 percent from 2001 to 2023, or just 0.4 percent per year on average. In comparison, Medicare hospital pay has increased roughly 70 percent between 2001 and 2023, with average annual increases of 2.5 percent per year for inpatient services and 2.4 percent for outpatient services. Notably, the cost of running a medical practice has increased 47 percent between 2001 and 2023, or 1.7 percent per year. Unlike nearly all other Medicare providers, physicians do not receive an annual inflationary payment update. When adjusted for inflation, which has been at levels not seen since the 1980s, Medicare physician pay has declined 26 percent from 2001 to 2023, or by 1.3 percent per year on average. CMS projects the increase in the costs to run a medical practice will be 4.5 percent next year but at the same time, physicians face a 3.36 percent reduction to the Medicare conversion factor in 2024.

These divergent payment updates put physicians at a significant disadvantage. Physicians who own and practice in independent offices must compete with HOPDs for the same clinician and non-clinical staff, equipment, and supplies, yet physician payments have failed to keep pace with inflation. Higher payments to HOPDs are also likely to incentivize the sale of physician practices to hospitals.

Achieving site-neutral payments for outpatient services and procedures will require increases in Medicare physician payment, so that practices can be sustained, and patient choice of care setting is safeguarded. Many policy proposals over the years have recommended simplistic, across-the-board solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting (i.e., lowering all services in the HOPD to MPS rates). However, shrinking payments to the lowest amount paid in any setting does not help physicians. The AMA does not believe it is possible to sustain a high-quality health care system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. As a result, the AMA advocates strongly that Congress allocate additional funds into the Medicare physician payment system to address increasing physician practice costs. **Specifically, the AMA and organized medicine strongly support H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," and urges Congress to provide physicians with much needed fiscal stability by passing this legislation, which provides an inflation-based payment update based on the Medicare Economic Index.**

HEALTH CARE WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

There is a projected shortage of between 54,100 and 139,000 physicians by 2033 on top of this 17,396 providers are needed to eliminate current primary care Health Professional Shortage Areas. This is particularly alarming since it is projected that there will be about a quarter fewer rural physicians practicing by 2030. In order to help curtail this shortage **more residency positions should be created**. "Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training."

In order to encourage more individuals to become physicians and to practice in areas that are most in need we recommend that:

- Congress should act to allow the cap on GME slots to be increased as needed to meet the nation's changing needs rather than remain stagnant. Also, the cap building period should be increased.

- The immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government. Moreover, the Teaching Health Center Graduate Medical Education, Rural Residency Planning and Development Programs, the National Health Service Corps, and the Indian Health Service should have their funding increased to bolster scholarships, loan forgiveness, and expand these programs.

- Support should be provided so that more institutions are incentivized to create rural training track programs.

- Holistic changes to how physicians are recruited need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical

school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound diverse clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural or underserved areas, support systems are needed.

To help alleviate the current and impeding physician shortage we strongly support:

- H.R. 2389/ S. 1302 the "Resident Physician Shortage Reduction Act," which would increase Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots.

- H.R. 4942/ S. 665 the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, as well as expand the total number of waivers available per state and make other targeted improvements to the program.

- H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act," bipartisan legislation that permits borrowers in medical or dental internships or residency programs to defer their student loans until completion of their educational training.

- H.R. 2761/ S. 705 the "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act," would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.

- S. 1403/ H.R. 3046 the "Medical Student Education Authorization Act," would reauthorize the MSE Program which provides grants to expand or support graduate education for physicians.

- Legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities. This would simultaneously achieve the important goal of diversifying the physician workforce in terms of economic background and geographic representation.

- Physician Shortage GME Cap Flex legislation, which would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages.

PHYSICIAN-OWNED HOSPITALS: IMPROVE COMPETITION AND QUALITY

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[14] This is partly the result of significant consolidation occurring in hospital markets around the country.[15] Many

[14] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, *Antitrust Applied*).
[15] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-

markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[16] Consolidation has real-life consequences, as clearly laid out in a recent book by Professors David Dranove and Lawton R. Burns about health care "megaproviders."[17] They found that in markets "where megaproviders dominate…, health care spending is higher, often much higher, and health care quality is no better, and sometimes lower."[18] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[19] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[20] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[21]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health care costs.[22] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[23] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[24] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[25] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[26] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[27] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[28] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[29] Many of the witnesses testifying before the House

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care/. (Accessed March 16, 2023), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[16] Martin Gaynor, *Antitrust Applied*, at 2.

[17] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021).

[18] Dranove, *supra,* at 178.

[19] Martin Gaynor, *Antitrust Applied*, at 5.

[20] Dranove, *supra,* at 178.

[21] Dranove, *supra,* at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.

[22] Martin Gaynor and Robert Town, *supra*.

[23] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.

[24] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages,* RAND Corporation, 3 (2020).

[25] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[26] Martin Gaynor, *Antitrust Applied*, at 4.

[27] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 International Journal of the Economics of Business 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems,* 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.

[28] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed July 14th, 2021), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/.

[29] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and*

Ways and Means Health Subcommittee echoed these views.

Increased Hospital Concentration is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets has a role to play in reducing the growth of disparities in health care access.[30] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[31] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[32] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

Antitrust Enforcement has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. Professors Dranove and Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[33] The antitrust response has been inadequate, notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[34] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot take action against anticompetitive conduct by not-for-profit entities; this presents a significant problem, considering how many hospitals are run as not-for-profits.[35] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the United States requires new remedies.

Congress Should Lift the Ban It Placed on Physician-Owned Hospitals

Fortunately, there is something Congress can do. Low-hanging fruit would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023" in order to remove a crucial barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs). As explained by Joshua Perry, in *An Obituary for Physician-Owned Specialty Hospitals,* 23 Health Lawyer 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law—meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 U.S.C. 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, under current law the POH cannot expand its treatment capacity unless certain restrictive exceptions are met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new POHs that depend on Medicare reimbursement.

Patient Outcomes in the National Health Service, 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

[30] Town, et al., *supra,* at page 10.
[31] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?,* 115 Q J Econ. 2, 577 (2000).
[32] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).
[33] Dranove, supra, at 178.
[34] Martin Gaynor, *Antitrust Applied*, at 17.
[35] Martin Gaynor, *Antitrust Applied*, at 18.

A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin entitled, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020), recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[36] Congressional action would be especially welcome because **POHs have developed an enviable track record for high quality and low-cost care**.[37]

Opponents of POHs argue that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" which they ascribe to the physician owners. However, the evidence indicates that POHs do *not* cherry pick patients. For example, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[38] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[39] Importantly, new economic research supports those findings. It finds strong evidence *against* cherry-picking by physician owners.[40]

Unfortunately, the POH ban forecloses the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models.[41] Benefits of self-referral in integrated delivery models include "one-stop shopping," improved sharing of clinical information, and better care delivery experienced by consumers. Critically, the ban on POHs is the wrong policy prescription to address potential concerns with self-referral models. There are other policy recommendations that do not sacrifice the benefits of POHs.[42]

Reversing the ACA-imposed ban on new construction or expansion of existing POHs will both stimulate greater competition and provide patients with another option to receive high quality health care services. An April 12, 2021 *Health Affairs* article entitled, *Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals*, explains how.

Much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law by enacting H.R. 977/S. 470 is the right prescription.

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[36] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).
[37] *Id.*
[38] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (2005) (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.
[39] *Id.*
[40] Ashley Swanson. *Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care.* 80 J Health Econ. (2021).
[41] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.
[42] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

FEWER BURDENS FOR BETTER CARE ACT

The AMA strongly supports the Fewer Burdens for Better Health Care Act and urges Congress to pass it. This bill would provide multi-stakeholder input on the removal of quality and efficiency measures from the Medicare program, which would help to ensure that the program is more efficient and effective for patients and physicians alike.

- November 1: CMS publishes list of measures being considered for addition *and removal*
- November 1: 30-day comment period begins, which is run by the consensus-based entity (CBE) (Battelle) to provide additional feedback for multi-stakeholder group consideration
- December - February: Multi-stakeholder group endorsement process, which wraps by February (as is current practice) – this part does not change, other than *requiring*, as opposed to just permitting, the CBE to consider measures to endorse for removal.

Shifting the timeline allows organizations, like AMA, the opportunity to provide more robust feedback on refining measures since it will move the process up, which currently conflicts with other measurers review processes in early December. Duplicative and antiquated administrative requirements need to be streamlined to ensure patient care is not being impeded by burdensome bureaucracy. The Fewer Burdens for Better Care Act gives providers a meaningful path to share how Medicare Quality Measures can be streamlined to improve the quality of care that patients receive.

SUNSHINE ACT

The AMA strongly supports the inclusion of important provisions of the Sunshine Act of 2023 (H.R. 9378), providing physicians with unrestricted access to the latest medical research and training materials to facilitate delivery of the best possible care. Inclusion of these measures rectifies a consequence stemming from a prior CMS practice of interpreting provisions of the Affordable Care Act to require that physicians report any continuing medical education events, as well as the distribution of medical textbooks and peer-reviewed journals, within the reporting scope. As a result, these educational resources became more challenging for physicians to obtain and hindered their ability to stay informed and updated. The noted Sunshine Act provisions, once enacted, will rectify this misinterpretation by exempting these crucial educational materials from reporting requirements. In so doing, negative impacts on physicians' access to up-to-date medical information will be minimized and providers' ability to provide the best care possible to their patients will be enhanced as a result.

CONCLUSION

The AMA is committed to working with the U.S. House of Representatives Committee on Energy and Commerce and Congress to find solutions that ensure that Medicare beneficiaries have access to high-quality, affordable health care. The AMA believes that the best way to achieve this goal is by reforming the MPS to make it more sustainable and equitable.

American Occupational Therapy Association

On behalf of the American Occupational Therapy Association (AOTA) I would like to thank the Committee for holding Thursday's hearing - *What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors*. I would particularly like to thank you for including the *Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation* (EMPOWER) Act (H.R.4878/S.2459), introduced by Representatives Deb Lesko (R-AZ) and Annie Kuster (D-NH) in this hearing.

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. AOTA would like to submit the following testimony for the record of Thursday's hearing.

Current Enrollment Trends – Applications are Decreasing.

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 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 programs training occupational therapy practitioners (OTPs).** Occupational therapy assistant (OTA) 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. The legislation under consideration today, is essential to helping to reverse these trends and to ensuring continued access to occupational therapy services, especially for people living in rural and medically underserved areas where fewer occupational therapy practitioners are available to treat patients.

The EMPOWER Act:

The *Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation* (EMPOWER) Act (H.R.4878/S.2459), introduced by Representatives Deb Lesko (R-AZ) and Annie Kuster (D-NH) would change the Medicare supervision requirement for occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) in private practice, from "direct" supervision to instead match state standards, which require only "general" supervision of OTAs by OTs in forty-nine states.

Occupational and physical therapy services are essential to helping people regain or maintain function that might otherwise be lost because of illness or injury. These services enable Medicare beneficiaries to maximize their independence and stay out of the hospital. On January 1, 2022, Medicare outpatient services provided by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) began receiving a 15% reduction in payment. This cut was separate from, and in addition to, other cuts to therapy payments under the Medicare Physician Fee Schedule over the last three years. The bill would also require the GAO to study the impact of the 15% payment reduction on access to therapy services in rural and underserved areas.

OTAs and PTAs complete a two-year associate degree or a bachelor's degree and are licensed in all 50 States, the District of Columbia, and Puerto Rico. Every state requires that OTAs and PTAs be supervised by an occupational therapist or a physical therapist. The bill's provision to standardize Medicare supervision requirements to match state regulation is a cost-effective way to reduce administrative burden

for private practice while recognizing the expertise and value of occupational therapy assistants, helping to increase access to services.

Medicare allows for “general supervision” of physical therapist assistants and occupational therapy assistants in all settings — except for private practice, which requires “direct supervision.” Therapy providers must already comply with their state practice act if state or local practice requirements are more stringent than Medicare’s. Currently 48 states require general supervision of physical therapist assistants, and 49 states require general supervision of occupational therapy assistants, making this Medicare regulation, that only applies to private practices, more burdensome than most state requirements**.**

The inconsistency of these supervision policies between settings jeopardizes employment opportunities for OTAs and PTAs as well as the needs of Medicare beneficiaries in rural and underserved communities that rely so heavily on their services. Standardizing the supervision requirement from “direct” to the state’s standard 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.

In rural and medically underserved areas the proportion of services provided by OTAs and PTAs is 50% higher than in other geographic areas, making these areas particularly dependent on services provided by assistants in order to ensure access to therapy. The bill 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.

A mock CBO score generated by Dobson DeVanzo & Associates predicted that this legislation **could save up to $242 million over 10 years as more services are provided by OTAs and PTAs in private practice settings.**

Occupational Therapy Services Have Faced Multiple Medicare Payment Cuts Since 2012

Like many health professions, occupational therapy (OT) has faced substantial challenges in recent years including decreasing enrollment in academic programs and burnout among practitioners. However, the profession has been particularly hard hit by steep Medicare payment reductions, and limited ability to participate in quality payment programs. While more Medicare beneficiaries received occupational therapy services in 2021 than they did in 2009, payment rates for therapy services have not kept up with inflation, rising by 9% over this time (with 7% of this increase occurring in 2009) compared to a 26% increase in the Medicare Economic Index. Starting in 2021, payments for OT services have been cut, with these cuts accelerating in 2022. Unlike other healthcare practitioners, OTPs have not made up the difference in payment through additional claims per beneficiary. The number of OT claims per beneficiary decreased from 29 claims per beneficiary in 2009 to 27 claims per beneficiary in 2021.

Occupational therapy practitioners and other therapy providers were particularly hard hit by CMS’s recent redistribution of resources on the physician fee schedule to increase payments for Evaluation & Management Codes. **Unlike other medical specialties, therapy providers are not allowed to bill evaluation and management codes.** As a result of this policy, if no further action is taken, OT services will receive a phased in cut of 9%, between 2021 and 2025, in addition to the reinstatement of the 2% sequestration.

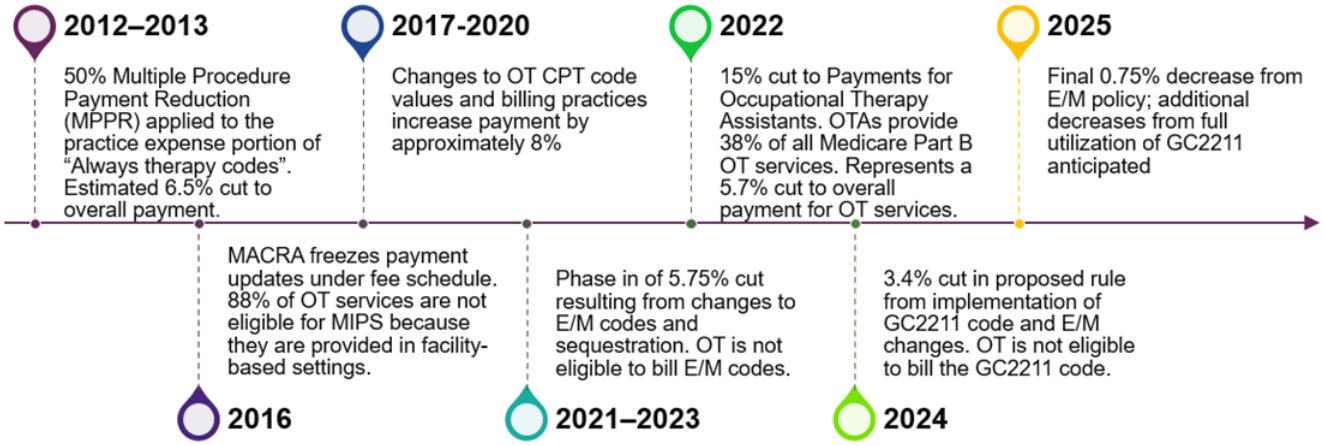
As noted above, compounding these cuts, reimbursement for services provided by occupational therapy assistants (OTA) and physical therapists assistants (PTA) were reduced by 15% starting in 2022. Outpatient Medicare services provided by OTAs comprise **37% of all outpatient therapy services**. In rural and underserved communities, **48% of all Medicare outpatient therapy services** are provided by OTAs, making them critical access points in these communities.

The lack of inflationary adjustments over the last 8 years, the more recent budget neutrality cuts, and the cut in payment to OTAs, are layered on top of existing therapy payment reductions. A 50% reduction to the

practice expense portion of “always therapy” codes was fully implemented in 2013. This multiple procedure payment reduction (MPPR) was codified by Congress, after originally being proposed by CMS.

Finally, unlike other providers, the vast majority of occupational therapy practitioners are not able to take advantage of quality incentive payments because they work in facility-based settings such as skilled nursing facilities and hospital outpatient departments. Facility-based services are not eligible for the Quality Payment Program which provides incentives for the delivery of high-quality care.

The following timeline shows the payment policies affecting occupational therapy services since 2012:



While many healthcare practitioners have faced challenges with Medicare reimbursement over the last decade, occupational therapy practitioners have been particularly hard hit. **If current policies are continued, the average occupational therapy service provided in 2025 will be paid 13% less than it would have been paid in 2012. This is without adjusting for inflation.** As Medicare reform is considered, we urge Congress to enact policies that will help preserve access to occupational therapy services under Medicare and reverse current policy trends which have reduced payment with no regard to the negative impacts on occupational therapy practitioners.

Given this history of payment cuts, we greatly appreciate the consideration of legislation that will help stabilize provider payments, including payments to occupational therapy practitioners, under the Medicare Physician Fee schedule. AOTA would particularly like to thank you for including the EMPOWER Act in this hearing. Thank you for your attention to these critical issues and for your consideration of the EMPOWER Act and other crucial legislation needed to stabilize the Medicare Physician Fee Schedule. Please let me know if I can be of any assistance to you in these efforts by contacting me at hparsons@aota.org .

Heather Parsons
AOTA Vice President of Federal Affairs
October 16, 2023

Alliance of Specialty Medicine

Sound Policy. Quality Care.

Alliance of Specialty Medicine

Statement for the Record

House Energy and Commerce Committee
Subcommittee on Health Hearing:

"What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

October 19, 2023

The Alliance of Specialty Medicine (Alliance) represents more than 100,000 specialty physicians across sixteen specialty and subspecialty societies. The Alliance is deeply committed to fostering patient access to the highest quality specialty care by advancing sound health care policy. We thank the committee and subcommittee leadership for the opportunity to provide our feedback for this important hearing. As patient and physician advocates, our members are eager to share our ideas to improve access for beneficiaries and minimize red tape for physicians.

Access Implications of Medicare Physician Fee Schedule Reimbursement Volatility

For 2024, the Centers for Medicare & Medicaid Services (CMS) has proposed another -3.4% reduction in physician reimbursement in the Medicare Physician Fee Schedule (MPFS). Labor prices, rent, medical equipment and supplies have increased rapidly over the past several years. Inflation impacts physician practices as much as it affects other Medicare providers, but the MPFS is the only Medicare payment system that lacks a mechanism to reflect annual inflation. That is not the case for most other Medicare providers, who anticipate increases in their 2024 payments, including inpatient hospitals (3.1%), inpatient rehabilitation facilities (3.4%), hospices (3.1%), hospital outpatient departments (2.8%) and Medicare Advantage plans (3.32%).

In its March 2023 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) noted that the Medicare Economic Index (MEI), which measures clinicians' input costs, grew by 2.6% in 2021 and an estimated 4.7% in 2022. These increases outpace the recent historical norm of 1% to 2% per year. MedPAC added that "Growth in clinicians' input costs is projected to remain high in 2023 (3.9 percent) and 2024 (2.9 percent)[.]" In light of this rapid growth in cost, MedPAC recommended that

Congress update the 2024 Medicare base payment rate for physicians by 50% of the projected increase in the MEI.

Medicare reimbursement volatility has system-wide impacts. One such consequence is that the increasing financial pressure on physicians continues to result in them being forced to sell their practices to larger, better-resourced entities. According to an American Medical Association survey of physicians, horizontal or vertical practice integration is driven by the need to reduce administrative burden and associated costs, improve access and lower the cost of needed practice resources, and improve negotiating power with private plans.[1] Consolidation remains a concern due to its impact on program spending. For example, recent research shows that hospital outpatient department charges can be more than double for the same service in the office setting.[2] Potential Medicare savings resulting from payment parity between the two settings have been predicted by the Congressional Budget Office (CBO).[3] Additionally, MedPAC has observed that "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."[4]

Thus, a domino effect results from Medicare's reimbursement instability for physicians: fewer physicians participate in the program, more physicians are forced to sell their practices, and, as noted above, costs for both the program and beneficiaries increase due to consolidation. This dynamic directly impacts access to care, especially for low-income beneficiaries and those living in rural or underserved areas.

Although CMS does not have the authority to implement an inflation proxy for the MPFS, it is worth noting that some of the agency's policy proposals in recent years have resulted in reductions by triggering budget neutrality requirements. For example, in the 2024 proposed rule, CMS proposes to:

- Implement a new Healthcare Common Procedure Coding System add-on code, G2211, that would provide payment for certain care provided to patients with complex health needs;
- Implement new codes and payment for a series of new services that aim to address health-related social needs; and
- Continue to phase in clinical labor pricing updates, which have already cut key Medicare services provided by specialists, such as drug administration services, among other things.

[1] https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf
[2] EBRI Issue Brief No. 525: "Location, Location, Location: Cost Differences in Health Care Services by Site of Treatment — A Closer Look at Lab, Imaging, and Specialty Medications" by Paul Fronstin, Ph.D., Employee Benefit Research Institute, and M. Christopher Roebuck, Ph.D., RxEconomics, LLC (Feb. 18, 2021).
[3] See, *e.g.*, Congressional Budget Office cost estimate for H.R. 5378, the *Lower Costs, More Transparency Act*, section 203 ("Parity in Medicare Payments for Hospital Outpatient Department Services Furnished Off-Campus").
[4] MedPAC, March 2020 Report to the Congress, Chapter 15 ("Congressional request on health care provider consolidation").

Putting aside the merits of these policies, due to budget neutrality, physicians' ability to receive reasonable payment updates is impacted as a result of CMS' proposal and implementation of them.

Solutions

The Alliance urges Congress to explore the following solutions to bring stability to the MPFS:

- In the short term, avert the reimbursement reduction proposed for Calendar Year 2024.
- Adopt the *Strengthening Medicare for Patients and Providers Act of 2024* (H.R. 2474), bipartisan legislation — led by Energy and Commerce Committee members, Reps. Raul Ruiz, MD (D-CA), Larry Bucshon, MD (R-ID) and Mariannette Miller-Meeks, MD (R-IA) — annually updating the MPFS based on the MEI.
- Increase the threshold at which budget neutrality is triggered (which has never been updated since it was first established in the early nineties) and then provide reasonable, periodic inflationary updates to that threshold. The *Provider Reimbursement Stability Act of 2023* incorporates such a provision.
- Direct CMS to establish a consistent and regular approach to updating direct and indirect practice expenses. As noted above, CMS is in the third year of a four-year phase-in of clinical labor price updates, a policy that has created significant reimbursement challenges for many specialties, again due to the budget-neutral nature of the MPFS. In fact, some Alliance specialties will be cut by as much as 22.04% for critical services they deliver due to this policy once fully implemented. These reductions were exacerbated by the fact that CMS had not updated these inputs in 20 years. The *Provider Reimbursement Stability Act* addresses this problem as well.

Specialist Engagement in the Quality Payment Program

The *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)* authorized several initiatives related to physician payment, including the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and the Quality Payment Program (QPP), which consists of the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM) track. Unfortunately, these initiatives have been implemented in ways that depart from the intent of the legislation that created them. As a result, they have not catalyzed meaningful movement towards higher-value care as effectively as desired, particularly for specialists, and in many instances, result in unnecessary regulatory burden and expenditure of resources.

Specialists have very few APMs in which to participate. At the same time, MIPS — the alternative to APM participation — has evolved into a pay-for-compliance rather than a pay-for-value program that is disjointed, administratively burdensome, and, for many specialties, not clinically meaningful. More specifically, MIPS suffers from overly complex and duplicative reporting requirements, annually shifting goalposts, and policies that often disincentivize developing and using specialty-specific quality measures. Even MIPS Value Pathways (MVPs), which are intended to include subsets of measures related to specialties, lack useful application for highly subspecialized fields like ophthalmology when they cut across an entire specialty. When developing and approving measures for traditional MIPS, as well as MVPs, CMS must accommodate measures focused on subspecialty care.

Because of these issues, many physicians struggle to find relevancy in the program and keep up with the cost of compliance. Recent research confirms the existence of these issues with MIPS, which have long been known to physician societies from members participating in the program. A 2021 study found that compliance with MIPS costs $12,811 per physician per year and that physicians and other clinical and administrative staff spend over 200 hours per physician per year on MIPS-related activities physicians.[5] The same year, the Government Accountability Office issued a report expressing concerns 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.[6]

Untapped Resource: Clinical Data Registries

MIPS fails to fully utilize data collection and performance analyses through clinical data registries. These registries collect and analyze data on a wide range of conditions, treatments, procedures, and diagnostics, allowing specialties to build a real-world evidence base that is impossible to establish based on administrative claims data alone. Registries also develop more targeted and nuanced quality measures, including patient-reported outcomes measures, which are often more useful to specialists and their patients than the inventory of traditional MIPS measures. Additionally, clinician-led data registries can provide more timely and actionable performance feedback than is currently available under MIPS. Given these attributes, clinical data registries are uniquely positioned to drive meaningful improvements in physician quality and the overall value of health care.

Unfortunately, CMS has adopted policies that conflict with the language in MACRA, which requires the Secretary of the Department of Health and Human Services (HHS) to encourage the use of qualified clinical data registries (QCDRs) for reporting quality data under MIPS. For example, QCDRs have been subject to rigorous measure testing standards and data validation requirements, without clear communication from CMS about these requirements. This makes the process of launching and maintaining a QCDR costly for specialty societies and prevents them from being nimble in terms of introducing new, more impactful measures. In fact, some specialties report that the cost of testing each QCDR measure can range from $30,000 to $100,000, which can add up to millions of dollars for QCDRs that steward numerous measures.[7] Additionally, electronic health record vendors continue to erect barriers that make it challenging and costly for registries to easily access such data, despite HHS taking steps in recent years to move the needle on interoperability standards and federal certification requirements to ensure better access to electronic health data. While QCDRs were supposed to offer specialists a pathway to introduce more focused and potentially innovative measures, the experience has been so disappointing that numerous prominent specialty society registries have decided that it is not a worthy investment to maintain their existing registries as QCDRs.

[5] This study was conducted based on 2019 data, prior to full MIPS implementation, and these costs are likely even higher today. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947
[6] https://www.gao.gov/assets/gao-22-104667.pdf
[7] Physician Clinical Registry Coalition, Dec. 2019 Letter to CMS re: QCDR Measure Testing Requirement.

Furthermore, Section 105(b) of MACRA directs the Secretary to provide Medicare claims data to QCDRs "for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety."[8] However, CMS has not provided clinician-led clinical data registries with a practical way to gain continuous, timely access to Medicare claims data, which has hindered our ability to perform more comprehensive data analyses, including meaningful assessments of cost-effectiveness, which is something that CMS is struggling with on its own under MIPS.

Advanced Alternative Payment Model Track

The QPP is an either/or program with two tracks. A provider either participates in MIPS or an Advanced APM. The latter track not only provides an exemption from MIPS but has provided substantial incentives to reward investments in value-based care models and higher base payment updates in 2026 and beyond. As of 2021, only about 270,000 clinicians qualified for the APM track, compared to almost 700,000 eligible clinicians for MIPS. Specialists, in particular, face barriers in identifying and joining relevant APMs in which to participate. For example, CMS attributes patients to APM entities based, in part, on the provision of primary care services. This has resulted in APM Entities intentionally excluding specialists who furnish proportionally more diagnostic tests and surgical procedures from their participant lists. Even when they join a model, methodological constraints often fail to incorporate specialists' contributions to higher-value care in the model. For example, CMS has adopted a quality measure set that applies to Medicare Shared Savings Program Accountable Care Organizations that is primary care-focused and not applicable to the services provided by specialists.

Additionally, CMS must take more direct steps to effectively engage more specialists in APMs, such as by testing and implementing more specialty-focused APMs developed by physician specialty organizations. Specialty physicians have faced challenges getting the Center for Medicare & Medicaid Innovation (CMMI) to test alternative payment and delivery models that are meaningful and feasible for specialists. Part of the problem is CMMI's apparent unwillingness to test models recommended by PTAC. Although PTAC has reviewed over 35 models and recommended several for implementation, CMMI has not yet advanced a single one of these in their original form. Because model development demands significant resources and expertise, this has been incredibly frustrating for Alliance members who have devoted those resources only to be stonewalled. More importantly, the lack of adoption significantly limits the ability of specialists to move into value-based models. Finally, it is critical that CMS maintain fee-for-service as an option for physicians who do not believe that APMs are appropriate for their practice or in the best interest of their patients.

Regulatory Burdens in QPP

Looking across CMS' value-based initiative portfolio, it is evident that CMS suffers from internal disorganization, which has resulted in excess spending and regulatory burden. Multiple offices within CMS manage similar but separate value-focused initiatives authorized by MACRA, with little apparent

[8] MACRA, Pub. L. No. 114-10, § 105(b)(1)(A).

coordination. For example, the staff responsible for administering the QPP seem disconnected from the CMMI staff responsible for administering APMs. Additionally, to carry out these initiatives, CMS relies on numerous separate contractors who are not coordinated with one another, which leads to confusion, inefficiencies, and situations where individuals are making important decisions with no institutional history and little understanding of the clinical implications of their recommendations and actions.

Solutions

The Alliance urges Congress to work with CMS to:

- Create more clinically relevant QPP participation opportunities for specialists. To that end, CMS should incentivize developing and using specialty-specific performance measures, payment models and other innovative approaches. CMS should also recognize physician participation in robust clinical data registries as an alternative for satisfying traditional MIPS requirements and incorporate clinical data registries into future specialty-focused payment models.
- Provide clinical data registries with meaningful access to Medicare claims data, allowing registries to conduct more comprehensive analyses of physician performance, including more meaningful evaluations of cost-effectiveness and overall value of care.
- Ensure that alternative participation pathways, such as MIPS Value Pathways, remain voluntary and that physicians have the flexibility to choose how to demonstrate their value most appropriately.
- Take steps to streamline and reduce the complexity and reporting burdens of the QPP. As noted, physician Medicare reimbursement has failed to keep pace with rising inflation, making it even more challenging for practices to prioritize investment in quality reporting compliance, particularly when many of those programs are of questionable value.
- Test and implement specialty-specific payment and delivery models developed by specialties and ensure that specialists have a meaningful role and do not face barriers to participation in existing APMs, where appropriate.

Administrative Barriers to Care

Utilization management protocols by insurers and pharmacy benefit managers have, in many cases, become mere tools to delay or outright deny medically needed care. For example, prior authorization is a cumbersome process that requires physicians to obtain pre-approval for medical treatments or tests before rendering care to their patients. Patients experience significant barriers to medically necessary care due to prior authorization requirements for items and services that are eventually routinely approved. Specialty physicians and their patients are often subject to prior authorizations and other utilization management tactics in the Medicare Advantage (MA) program. Generally, these processes delay beneficiary access to medically necessary care and create considerable, unnecessary administrative burdens for the physician. Equally concerning, these tactics are a leading cause of physician burnout, forcing many to retire early or leave the practice of medicine. While utilization management processes may be appropriate in some situations, the Office of Inspector General has found that MA plans use prior

authorizations to deny *medically necessary* care, that is, care that meets coverage requirements under traditional Medicare and is supported by the enrollee's medical records. [9]

Last year, the Alliance of Specialty Medicine surveyed specialty physicians on the topic of utilization management. The findings underscore the burden of utilization management protocols on the practice of medicine, both in terms of the negative impact on patient care and the increased administrative onus on medical practices. Respondents overwhelmingly indicated that the use of prior authorization has increased in the last five years across all categories of services and treatments:

- Over 93% of respondents answered that prior authorization has increased for procedures;
- More than 83% answered that prior authorization has increased for diagnostic tools, such as labs and even basic imaging; and
- Two-thirds (66%) responded that prior authorization has increased for prescription drugs, with physicians noting that even many generic medications now require pre-approvals.

Another problematic form of utilization management is step therapy. Step therapy protocols require patients to try and fail an insurer-preferred medication before being covered for the physician-prescribed medication. This can have devastating health consequences for patients, particularly those with progressive conditions causing irreversible damage. Patients with chronic and/or complex diseases such as inflammatory bowel disease, rheumatoid arthritis, cancer, psoriasis, or age-related macular degeneration may respond differently to various medications used to treat these diseases. Long-term health care costs increase when patients are forced to fail first on a treatment and experience adverse events that can lead to hospitalization or other interventions.

Solutions

- The Alliance supports efforts to reduce administrative burdens and ensure safe, timely, and affordable access to care for patients. We support the *Improving Seniors' Timely Access to Care Act*, which unanimously passed the House of Representatives in the last Congress. The solutions included in this legislation, along with new regulations issued by CMS, will go a long way to ensuring that our nation's seniors get the care they need at the time they need it.
- The Alliance also supports the *Safe Step Act* (H.R. 2630/S. 652) to reduce barriers to care and improve patient outcomes. The *Safe Step Act* will help patients and physicians by requiring insurers to implement a transparent and fair appeals process that is easily accessible on the plan's website and allows for an exemption to step therapy in certain clearly delineated scenarios. The legislation would also establish a time frame in which insurers must respond to appeals to ensure that patients can receive appropriate treatment in a timely manner.

Conclusion

The Alliance of Specialty Medicine thanks the Subcommittee for its focus on beneficiary access and administrative burden reduction across all aspects of the Medicare program. We hope that the

[9] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

Subcommittee finds our proposed solutions helpful and actionable, and we welcome the opportunity to provide additional information, should that be helpful as Congress advances these policies.

American Urological Association

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October 19, 2023

The Honorable Cathy McMorris Rodgers, Chair
House Energy and Commerce Committee
U.S. House of Representatives
2188 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie, Chair
House Energy and Commerce Subcommittee on Health
U.S. House of Representatives
2434 Rayburn House Office Building
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Re: Statement for the Record, Hearing on "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

Dear Chair McMorris Rodgers and Subcommittee Chair Guthrie:

The American Urological Association (AUA) applauds the Energy and Commerce Committee and the Health Subcommittee for holding this important legislative hearing on Medicare payment and quality policies. The AUA is a globally engaged organization with more than 22,00 physician, physician assistant, 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. As such, 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 subcommittee for holding this legislative hearing to examine policies to improve Medicare beneficiary access to care and ensure the care delivered by urologists and other physicians is reimbursed equitably.

Background

Physician payments have stagnated for the last two decades while hospitals and physician practices must continue to pay market rate for supplies, equipment, and staff wages. According to an American Medical Association analysis of Medicare Trustees data, Medicare physician payment has been reduced by 26%

when adjusted for inflation from 2001–2023.[1] For the last three 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.

For Calendar Year (CY) 2024, CMS has proposed a 3.4 percent cut to the MPFS conversion factor from $33.887 to $32.7476. This reduction is the result of a statutory 0% update scheduled for the MPFS in 2024, a negative 2.17% RVU budget neutrality adjustment, and the expiration of part of the funding Congress allocated to the MPFS at the end of 2022 through the Consolidated Appropriations Act (CAA) of 2023. In our comments on the CY 2024 MPFS proposed rule, the AUA stated, "urologists and other physicians continue to face budgetary challenges as operational and clinical labor expenses continue to increase and Medicare reimbursement has stagnated. **The proposed conversion factor cut exacerbates these challenges, undermining urologists' capacity to provide optimal patient care while sustaining viability of their practices."**

Additionally, CMS continues to implement updates to the clinical labor rates used to calculate the practice expense of physician services. The agency began phasing in these updates in the CY 2022 MPFS final rule. While these clinical labor rates were overdue for an update, reimbursement for services with high supply and equipment costs decreased because of the budget neutral nature of the MPFS, placing additional pressure on physicians and their practices to meet their continually increasing practice costs.

These increasing financial pressures are forcing physicians and specialty societies, like the AUA, to evaluate all policies in the context of how they may erode reimbursement for MPFS services. As an example, CMS requested comment on the addition of services to the MPFS better address beneficiaries' social needs, including a G-code for social determinants of health assessments and principal illness navigation services, in the CY 2024 proposed rule. While these services may reimburse physicians for medically appropriate care and improve health outcomes over time, the AUA recognized that in a budget neutral system, particularly with no statutory updates to the conversion factor, the

[1] https://www.ama-assn.org/practice-management/medicare-medicaid/medicare-physician-pay-fell-26-2001-how-did-we-get-here

addition of new services to the MPFS erodes the value of already reimbursed services and requested that CMS clearly examine and articulate the financial implications of these policies. The AUA and other specialty societies should be evaluating these policies on their merits and their potential to improve Medicare beneficiaries' health; however, the financial constraints the outdated Medicare payment policies are placing on physicians and their practices is making the budget neutrality implications paramount when evaluating potentially innovative policies and services.

Legislative Solutions

Given these growing financial pressures, the AUA appreciates the Health Subcommittee's examination of legislative solutions to improve MPFS payment policies. Specifically, we offer the following comments on the legislation being considered at this hearing:

The Provider Reimbursement Stability Act of 2023

The AUA applauds the GOP Doctors Caucus co-chairs for releasing this discussion draft. We believe this legislation, if implemented with other MPFS reform policies, will begin to reverse the downward trajectory of MPFS reimbursement.

The AUA believes that budget neutrality places unreasonable constraints on MPFS payments and potential policies. This legislation would increase the budget neutrality threshold to $53 million and provide for an increase equal to the cumulative increase in the Medicare Economic Index (MEI) every five years; this represents the first substantial increase to the fee schedule since 1992. Additionally, it will allow CMS to more accurately calculate the conversion factor by allowing corrections for over- or underestimates in utilization of services added to the MPFS. These policies represent significant improvements to the MPFS' budget neutrality requirements and will mitigate some of the downward pressure on the conversion factor.

Additionally, this legislation addresses practice expense updates, another driver of recent conversion factor decreases. When CMS updated the clinical labor inputs in CY 2022, the existing inputs were almost two decades old. By providing for prices and rates for direct practice expense inputs to be updated every five years, this policy will mitigate unusually large budget neutrality adjustments stemming from overdue updates and will ensure that Medicare reimbursement policy better reflects the current market. In our CY 2024 MPFS proposed rule

comments, AUA recommended that CMS update these inputs on a more regular basis.

The final portion of this legislation limits positive or negative increases in the conversion factor to no more than 2.5 percent annually. The AUA appreciates the intent to limit particularly large decreases in MPFS reimbursement; however, we caution the committee against limiting positive conversion factor increases to 2.5 percent. By placing a cap on potential increases, the MPFS would not be able to keep pace with actual costs, particularly in times of high inflation like we have been experiencing in the United States over the last two years.

The AUA has endorsed the *Strengthening Medicare for Patients and Providers Act of 2024* (H.R. 2474), bipartisan legislation introduced by Representatives Larry Bucshon, Mariannette Miller-Meeks, Raul Ruiz, and Ami Bera that would provide a statutory update to the MPFS based on the MEI. Every Medicare fee schedule, except the MPFS, includes a statutory update, and this legislation finally would provide an inflationary update for physician payment. We believe that Congress must adopt H.R. 2474 along with the majority of the provisions of the *Provider Reimbursement Stability Act of 2023*.

The Providing Relief and Stability for Medicare Patients Act of 2023 (H.R. 3674)
This bipartisan legislation introduced by Representatives Gus Bilirakis, Tony Cardenas, Greg Murphy, and Danny Davis addresses the disproportionate impact of CMS clinical labor update policy on specialists practicing in community settings by increasing the non-facility practice expense relative value units negatively impacted by this policy for the next two years. The impact of these cuts, particularly in conjunction with the other policies exerting downward pressure on the conversion factor, has been particularly difficult for specialists in community-based settings to absorb. Given the limited access Medicare beneficiaries have to specialists in rural and underserved areas, this legislation is a key step to prevent additional access barriers. As the AUA outlined in our CY 2024 MPFS comments, CMS must regularly update practice expense inputs to prevent large relative value unit redistributions to maintain budget neutrality. H.R. 3674 will mitigate the financial challenges specialists in community based settings are facing and should be considered in conjunction with the practice expense input policy outlined in the *Provider Reimbursement Stability Act of 2023.* The AUA urges this committee to support this legislation.

The Improving Seniors' Timely Access to Care Act (H.R. 4822)
Medicare Advantage (MA) prior authorization policies place a significant administrative burden on physicians and other clinical staff who must spend

time responding to these requirements rather than delivering patient care. With more than 50 percent of Medicare beneficiaries enrolled in MA plans rather than traditional Medicare in 2023, the burden these PA policies impose is significant.[2] The AUA believes this legislation will improve transparency and oversight of the MA program and its prior authorization requirements, potentially reducing the burden of physicians, and urges the committee to advance this legislation.

[2] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/#:~:text=More%20than%20half%20of%20eligible,enrolled%20in%20Medicare%20Advantage%20plans.

Statement of the American College of Surgeons
to the Committee on Energy and Commerce
Health Subcommittee
United States House of Representatives
RE: What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors
October 19, 2023

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On behalf of the more than 88,000 members of the American College of Surgeons (ACS), we thank you for convening this hearing entitled "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." The topic of this hearing as well as the legislation under consideration are of the utmost importance for ensuring that our country's seniors have equitable access to timely, high-quality care. To achieve this, ACS holds that it will be necessary to shift from the current game of penalty avoidance across the multitude of reporting programs to a system built on quality programs for specific conditions, aligned with the team-based nature of care delivery. Such a shift will furthermore require measures to produce information that supports both patients and referring physicians when they must determine where to seek medical care. Unfortunately, the measures frequently used in the current environment do not achieve this. We thank Congress for their willingness to consider legislation that would improve Medicare patients' ability to find and access safe, affordable care that meets their individual goals by meeting the above objectives.

A number of the bills being considered at this hearing have the potential to make an impact on not only reducing the burden to physicians and access to care, but also on improving care coordination and the information available to patients seeking care that meets their needs. The ACS is especially pleased to see bills addressing prior authorization, shortcomings of current budget neutrality requirements in the physician fee schedule, assuring proper compensation to ensure access in rural areas and legislation to create flexibility in measurement that will foster greater care coordination in team-based, facility settings.

The ACS remains committed to improving the care for all surgical patients and has done significant work to ensure Medicare beneficiaries receive the highest quality of care. We appreciate the opportunity to describe some of the recent work the ACS has undertaken to improve surgical quality and value and provide some steps Congress can take to improve the current system.

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 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 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 2015 level;
- 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 improvements 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 to meaningfully participate in since none of the models submitted to the PTAC have been tested as proposed.

A foundational step necessary to maintain access and improve quality for patients is immediate reversal of any additional cuts to the Medicare physician fee schedule planned for 2024 and beyond and 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

In order to maintain and improve access to care for Medicare patients it is important that we adequately and appropriately compensate all physicians and providers involved in their care. For more than 20 years, Medicare payments have been under pressure from Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a relatively modest portion of overall federal health care spending, they are perennial targets for cuts when policymakers seek to tackle affordability. The Medicare PFS is unique in its lack of a meaningful mechanism to account for inflation and remains constrained by a budget-neutral financing system. Updates to the Conversion Factor (CF) have failed to keep up with inflation and in recent years have been negative, with additional cuts to Medicare physician payments expected in 2024.

These yearly compounding cuts, combined with high inflation, a lack of updates to account for increased expenses, and a lack of viable alternative payment models for surgeons, demonstrate that the Medicare payment system is broken. These systemic issues will continue to hinder surgeons' ability to undertake important quality improvement initiatives or make investments needed to move toward value-based care. There are several steps Congress can take to stabilize Medicare payment in the near term and reform the system in the long term.

<u>Stop Pending Payment Cuts for 2024</u>

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

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

Establish an Annual Inflationary Update

In order to ensure Medicare payments keep pace with the medical cost inflation, **Congress should pass legislation to provide an annual update to the Medicare physician fee schedule comparable to that in other payment programs starting with calendar year 2024**. The ACS supports the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide an annual inflationary update to the conversion factor based on the Medicare Economic Index. This legislation, introduced by Representatives Raul Ruiz, M.D. (D-CA-25), Larry Bucshon, M.D. (R-IN-08), Ami Bera, M.D. (D-CA-06), and Mariannette Miller-Meeks, M.D. (R-IA-01), would allow physician reimbursement to be adjusted for inflation in line with other Medicare providers such as hospitals, nursing homes, and home health providers.

Address the Problematic Budget Neutrality Requirements under the PFS

The statutory requirements for budget neutrality under Medicare is unique to the physician payment program and has been an underlying factor in why the payment system is broken. It requires CMS to implement across-the-board cuts to the conversion factor if changes to the Medicare physician fee schedule cause expenditures to exceed $20 million annually. This trigger amount has remained the same since its implementation in 1992. **The ACS strongly believes that at a minimum, 42 USC 1395w-4 (c)(2)(B)(ii) should be amended to increase the current $20 million budget neutrality adjustment trigger and index it for inflation going forward.**

Adjust the Global Surgical Code Values to Reflect Increased E/M Values

Medicare currently pays surgeons and other specialists a single fee (global payment) when they perform major or minor surgery such as back surgery, brain tumor removal, joint replacement, heart surgery, cataract surgery, colon resection, or provide maternity care. This single fee covers the costs of the surgery plus related care prior to surgery and follow-up care within a 10- or 90-day timeframe. CMS establishes these global payments, including payment for both the surgical procedure and payment for post-operative/follow up visits, which are a type of E/M visit. Post-operative services include follow-up visits in the hospital related to recovery from the surgery; post-surgical pain management; local incision care; removal of sutures and staples, lines, wires, tubes, drains, casts, and splints; and other services.

Since 1997, CMS increased the E/M portion of the global code values to reflect increases in the stand-alone E/M codes each time these office visit codes were adjusted. In 2021, CMS did not apply the adjusted values to the 10- and 90-day global surgical codes. This decision disrupted the relativity in the fee schedule mandated by Congress as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (P.L. 101-239). Additionally, the Medicare statute prohibits CMS from paying physicians differently for the same work. Failing to adjust the global codes is equivalent to paying some physicians less for providing the same E/M services**. Global surgery payments must be modified to include the current stand-alone E/M payment levels as adjusted in 2021.**

These are only short-term measures that must be enacted by the current Congress and Administration, as we work together in the next few years toward a more sensible system of physician payment that accounts for quality and value. ACS supports building a more modern and equitable care environment for patients, rewarding value and innovation. Addressing 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. Congress and CMS should encourage innovation in value-based payment models that provide and utilize timely, actionable data to 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 not only facilitate better care but 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 implementation 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 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.

The ACS thanks Rep. Neal Dunn, M.D. (R-FL-02) for his leadership on developing legislation to extend the incentive payment for participation in eligible APMs. The APM incentive was intended to attract early participants to models developed under MACRA's new pathway. However, it is critical that the Innovation Center advance physician-developed models which have been reviewed and recommended for testing and implementation in order for this incentive to fully be effective. **Congress should require that at a minimum, some portion of the CMS Innovation Center's budget be dedicated to testing APMs recommended by the PTAC.**

Improving MACRA to Ensure Meaningful Quality Measurement and Reduce Reporting Burden

Most physicians in the current fee-for-service system are currently evaluated on measures that do not reflect the care they deliver to patients or the conditions they treat. This means that no information is available for improvement or to help patients choose the best care for them. ACS's efforts have been designed to overcome barriers faced by surgeons (and other physicians) who currently must expend time and resources on meaningless, check the box measures. Based on these efforts and the more than 100-year history of ACS working to improve the quality and value of care for surgical patient, the ACS believes addressing the current limitations on the types of quality measures available as well as the limitations on the facility-based scoring option 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 have recently been notified that the measure will be included on the MUC list with further action expected in November. 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 from 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. 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:

1) Eliciting Patient Healthcare Goals;
2) Responsible Medication Management;
3) Frailty Screening and Intervention;
4) Social Vulnerability; and
5) Age Friendly Care Leadership

If adopted, the Age Friendly Hospital Measure could be further enhanced through an expansion of the facility-based scoring option of the Quality Payment Program. Facility-based scoring opportunities are currently limited to very specific circumstances. These opportunities should be expanded and enhanced 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, not just 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 sees quality as a comprehensive program. This program is 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 areas where regional shortages in surgeons and

other care providers can lead to reduced access and fewer choices for care. The ACS developed programs like GSV and QVP have demonstrated 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. This is why alignment with facility reporting is critical for care organized around a 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. The ACS thanks Rep. Larry Bucshon, M.D. (R-IN-08) for sponsoring legislation on this issue and we thank the Subcommittee for considering these important improvements to MIPS.**

In addition to increasing care coordination and reducing reporting burden, such a proposal could lead to a reduction in federal health care spending. The ACS experience with a programmatic approach to quality has demonstrated that such an investment can result in fewer costly complications and readmissions and ultimately in lives saved. The ACS has recently launched the Power of Quality Campaign and is partnering with hospitals to help them let patients know of their commitment to surgical quality. Hospitals who successfully participate in one of 13 ACS programs will now be able to display a Surgical Quality Partner diamond emblem to demonstrate their commitment to quality improvement and the best possible outcomes for surgical patients. This type of information is much more valuable and actionable to patients than what is typically provided by current measures used in federal programs as they make decisions about where to receive care.

Prior Authorization Reform Will Help Patients and Reduce Administrative Burden

Surgical patients are encountering barriers to timely access to care due to onerous and unnecessary prior authorization (PA) requests from Medicare Advantage (MA) plans. Utilization review tools such as PA can sometimes play a role in ensuring patients receive clinically appropriate treatment while controlling costs. However, ACS is concerned about the growing administrative burdens and the delays in medically necessary care associated with excessive PA requirements. A 2017 ACS questionnaire of nearly 300 surgeons and practice managers indicated that, on average, a medical practice receives approximately 37 PA requests per provider per week, taking physicians and staff 25 hours – the equivalent of three business days – to complete. Since then, Fellows have shared that this burden has grown significantly. Despite more automation since that time, payors are applying PA to an increasing number of services and use digital/AI tools to automatically deny PA and/or claims without any review of the medical record.[1] We appreciate the Energy and Commerce Committee's continued leadership in addressing the overutilization of prior authorization**. ACS strongly supports the Improving Seniors' Timely Access to Care Act. This legislation would improve continuity of care and reduce excessive administrative burden by facilitating electronic prior authorization, improving transparency, and increasing CMS oversight on how MA plans apply PA requirements.**

Congressional Action is Needed to Improve MIPS and APM Participation: In Summary

The value-transformation is underway but could be greatly accelerated through a combination of shoring up the foundation of the physician fee schedule and partnership between CMS and stakeholders interested

[1] https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims

in improving the way quality is measured and incentivized. Congress has the power to provide CMS with direction, flexibility, or additional authority to help them 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;**
- **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 as proposed in one of the bills being considered at the hearing.**

These are relatively modest reform ideas that stabilize the physician fee schedule and build on MACRA to put the focus back on providing high value care to the patient. Surgeons are eager to be part of the solution and to work with Congress to advance critical reforms. The ACS thanks you for convening this important hearing on improving the Medicare payment system and for the committee's consideration of policies that advance quality and value for patients. We share this commitment and look forward to working collaboratively with the committee to achieve the goal of safe, affordable care for all Americans.

A Study of the Cost of Care Provided in Physician Owned Hospitals Compared to Traditional Hospitals

Analysis of 20 High-Cost Diagnostic Related Groups Using 2019 Medicare Claims Data

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Introduction

The research literature on the cost and quality of care provided by physician owned hospitals (POHs) relative to traditional hospitals is sparse. In a recent systematic review of the literature, Miller et al. (2021) found only 21 studies published between 2005 – 2019 that met inclusion criteria based on the study population, the outcomes measured, and study design considerations.[1] Emerging from these studies, however, was a clear pattern of POHs providing higher quality care at lower or comparable cost, particularly in the cardiac and orthopedic specialty service markets. These findings were supported in a recent study by Wang et al. that found median commercial negotiated prices and cash prices were approximately one-third lower in general acute care POHs relative to traditional hospitals in their service areas for most common hospital procedures.[2] In contrast, two recent reports submitted to the American Hospital Association and Federation of American Hospitals found a number of cost and quality differences favoring traditional hospitals relative to POHs.[3,4]

To add to and further clarify the data on cost differences between POHs and traditional hospitals, this report summarizes results from an investigation comparing the cost of care in POHs with traditional hospitals for Medicare patients in the 20 most expensive diagnostic related groups (DRGs) for 2019. Cost of care is defined in this report as the total amounts paid by Medicare plus any beneficiary or primary insurer payments. By estimating a series of mixed effects regression models to predict the total cost associated with discharges for each DRG, we were able to compare POHs to traditional hospitals within the same hospital referral region (HRR) to adjust for regional differences in reimbursement. Separate models were estimated for each DRG, and all models controlled for patient demographic characteristics – age, sex, and race and ethnicity – as well as measures of patient comorbidities to account for potential differences in the patient populations among traditional hospitals and POHs.

Methods

Data and Measures

A list of 216 POHs operating in the United States was obtained from Physician Hospitals of America. Comparator hospitals in the same hospital referral regions as the POHs were identified using data from the Dartmouth Atlas Project.[5]

Cost data and patient characteristics were derived from the 2019 Medicare inpatient dataset (the MedPAR Limited Data Set) purchased from the Centers for Medicare and Medicaid Services. Patient-level Medicare fee-for-services claims in this dataset were aggregated by facility for each of the DRGs included in the analysis. Total payment was calculated by summing Medicare, beneficiary and primary payer paid amounts.[6] Discharges for which the total Medicare and beneficiary payment was zero (reflecting procedures lacking prior authorization, noncovered services or circumstances, coordination of benefit issues, or never events) were excluded from the analysis. Note that while this filtering reduced the number of discharges in POHs to slightly less than 1000 for DRGs 468 and 473, we retained these DRGs in the analysis.

The clinical conditions included in this analysis consisted of the 20 DRG codes accounting for the largest cumulative total payments in POH hospitals (excluding DRGs with fewer than 1000 total discharges across all POHs). DRGs included in the analysis were: Respiratory infections and inflammation with MCC (DRG 177); Pulmonary edema and respiratory failure (189); Chronic obstructive pulmonary disease with MCC (190); Simple pneumonia and pleurisy with MCC (193); Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries (246); Percutaneous cardiovascular procedures with drug-eluting stent without MCC (247); Acute myocardial infarction, discharged alive with MCC (280); Heart failure and shock with MCC (291); Combined anterior and posterior spinal fusion with CC (454); Combined anterior and posterior spinal fusion without CC/MCC (455); Spinal fusion except cervical without MCC (460); Revision of hip or knee replacement without CC/MCC (468); Major hip and knee joint replacement or reattachment of lower extremity without MCC (470); Cervical spinal fusion without CC/MCC (473); Major joint or limb reattachment procedures of upper extremities (483); Renal failure with MCC (682); Kidney and urinary tract infections without MCC (690); Infectious and parasitic diseases with operating room procedures with MCC (853); septicemia or severe sepsis without MV >96 hours with MCC (871); Septicemia or severe sepsis without MV >96 hours without MCC (872).

Measures of patient's demographic characteristics and level of comorbid health conditions were derived from the MedPAR LDS and included patient's age (<65; 65-74; 75-84; 85+), sex (male vs. female), and race/ethnicity (White/non-Hispanic; Black/non-Hispanic; Hispanic/Latino, Other race). Patient comorbid health conditions were measured by the Elixhauser comorbidity index, a widely used and empirically validated measure consisting of 30 categories of comorbid diagnoses.[7] The Elixhauser summary score reflects the sum of the patient's number of comorbid conditions across these 30 diagnostic categories.[8]

Analysis

We estimated mixed effects regression models predicting total payments for each DRG using R version 4.1.3.[9] Total payments were log transformed to account for the right skewness of the payment distribution. A random intercept was included in each model to account for the differences in reimbursement rates across hospital referral regions. The key predictor variable was a binary indicator for POH/non-POH status, and all models controlled for patient demographic characteristics and the Elixhauser comorbidity score.

Results

From the initial list of 216 POHs we removed 30 that either did not treat Medicare patients or did not treat patients with any of the DRGs included in our analysis, resulting in a total of 186 POHs providing 89,217 patient discharges for analysis. We then identified traditional hospitals within the same HRRs as POHs (N = 1230). For each DRG we limited the analysis to traditional hospitals operating within the same HRR as at least one POH and included only those facilities

with greater than 10 discharges within each DRG. This yielded a total number of traditional hospitals included in the analysis to 1230 and the total number of discharges across the 20 DRGs to 650,386.

Figure 1 presents a map of the US displaying POHs (red dots) and traditional hospitals (gray dots) included in the analysis. The numbers of POHs and traditional hospitals included in the analysis by state and hospital referral region is presented in Table 1. In Table 2 we present the numbers of facilities and numbers of discharges for each DRG analyzed.

Figure 1

Table 1

Table 2

Table 3 presents differences in patient demographic characteristics between POHs and traditional hospitals for each DRG. Given the large sample sizes, statistically significant differences at the .01 level in the age distributions of patients were observed in 11 of the 20 DRGs. In most cases, however, the percentages of patients in the more challenging age groups – i.e., under 65 and over 85 – varied by no more than a few percentage points between the two hospital types. Moreover, there was no clear pattern to these differences; for several DRGs POHs had a slightly more challenging age profile than did traditional hospitals. The only notable age difference was DRG 470 (Major hip and knee joint replacement or reattachment of lower extremity without MCC), where traditional hospitals had twice as many patients over 85 than did POHs (10.8% vs 4.7%).

Statistically significant differences at the .01 level in the race/ethnic distributions of patients in POHs and traditional hospitals were observed in 14 of the 20 DRGs, with traditional hospitals having a higher percentage of White patients. As was the case with age, however, the magnitude of the differences in the percent of White patients treated in these hospitals was very small, generally varying by 2-3 percentage points. In only two DRGs did the proportion of White patients differ by 4 percentage points: DRG 291 (Heart failure and shock with MCC: 78.2% POH vs. 74.0% traditional) and DRG 189 (Pulmonary edema and respiratory failure: 84.6% POH vs. 80.5% traditional).

Statistically significant differences at the .01 level in the comorbidity counts among patients in POHs and traditional hospitals were observed in only 9 of the 20 DRGs. Lower counts were observed in POHs relative to traditional hospitals in all but one case, but these differences were of very small magnitude, ranging between .1 and .25 comorbidities. Finally, there were virtually no statistically or substantively meaningful sex differences in these two patient populations.

Table 3

Table 4 presents a crude comparison of the mean payment per discharge in each DRG for POHs and traditional hospitals. Note that these numbers do not include controls for differences in patient characteristics. Across all 20 DRGs the mean total payments were substantially lower in POHs. The smallest difference in average payment was for cervical spinal fusion without CC/MCC (DRG 473), where the average payment was 10.1% lower in POHs compared to traditional hospitals. The largest difference in payment was for septicemia or severe sepsis without MV >96 hours with MCC (DRG 872), where the average payment was 19.3% lower for POHs.

Table 4

Table 5 presents results from mixed effects regression models in which the log of total payments were regressed on POH status, patient demographic characteristics and Elixhauser comorbidity scores. A random intercept for HRR was included in all models to account for variability in payment across hospital referral regions. Table 5 shows that for all 20 DRGs, the coefficients for the POH indicator variables were negative and highly statistically significant (with p-values adjusted for multiple comparisons using the Benjamini-Hochberg adjustment).[10] This indicates that POHs received significantly lower average total payments than traditional hospitals for all DRGs, controlling for patient's demographic characteristics and comorbid health conditions. To derive cost differences between POHs and traditional hospitals when controlling for patient demographics and comorbidities, we used the regression coefficients from this model to calculate the expected differences in average total payments. Results from this analysis are presented in Table 6 and indicate that the differences in payments between POHs and traditional hospitals across all 20 DRGs ranged between 8.6% and 15.2% when adjusting for differences in patient mix.

Table 5

Table 6

Conclusions

For the 20 highest cost DRGs treated by POHs in the US, our analysis of 2019 Medicare claims data indicates that total payments were between 8-15% lower than in traditional hospitals within the same market. Mixed effects regression models indicated that differences between POHs and traditional hospitals in the demographic characteristics or comorbidity profiles of their respective patient populations did not account for these payment differences. In general, the patient populations of POHs and traditional hospitals were very similar, with few substantively meaningful differences by race and ethnicity, sex, age and patient sickness.

Our analysis indicates that substantial savings to the Medicare program could be achieved were traditional hospitals able to provide care at the same cost as POHs in their area. According to the MedPAR data we analyzed for this report, the total cost of care for these 20 DRGs in

traditional hospitals in these markets would have been reduced by approximately $1.1 billion in 2019, a 12.2% reduction, if reimbursed at the same rate as POHs. When considered in light of Wang et al.'s (2023) findings of substantially lower commercial reimbursement rates among POHs, our results suggest that POHs may offer an opportunity to achieve considerably lower costs of care across a range of health conditions and patient populations.

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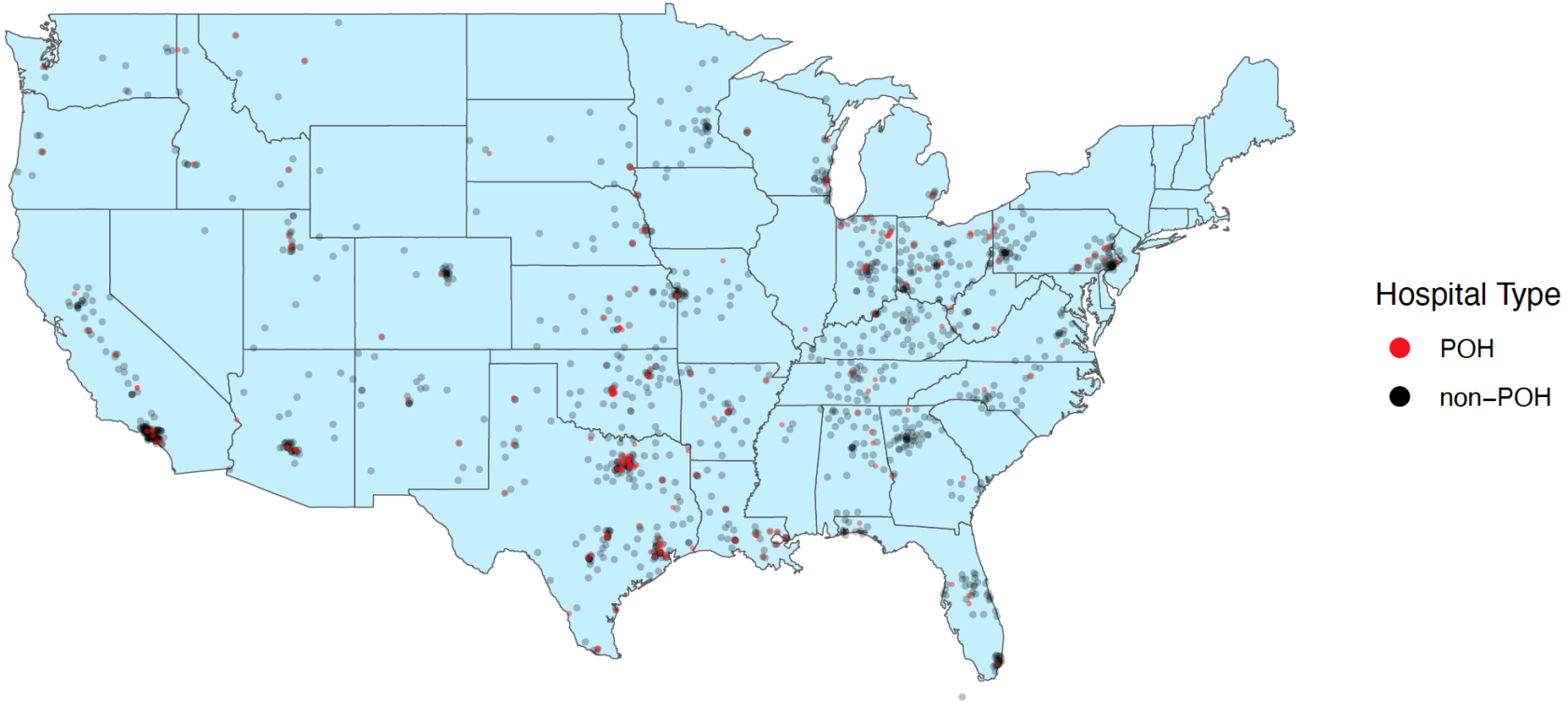
Figure 1. Distribution of physician owned hospitals and traditional hospitals operating in the same hospital referral regions.



Note. Darker colors indicate a greater concentration of hospitals in an area.

Table 1. Numbers of POHs and traditional hospitals included in the analysis, by hospital referral region and state.

HRR City	State	Traditional hospitals	Physician owned hospitals
Anchorage	AK	7	1
Birmingham	AL	30	3
Huntsville	AL	5	1
Jonesboro	AR	3	1
Little Rock	AR	21	3
Springdale	AR	5	1
Texarkana	AR	2	1
Mesa	AZ	10	2
Phoenix	AZ	25	3
Bakersfield	CA	8	2
Fresno	CA	5	1
Los Angeles	CA	71	4
Modesto	CA	5	1
Orange County	CA	21	2
Sacramento	CA	18	1
Denver	CO	21	1
Hudson	FL	4	1
Miami	FL	21	1
Orlando	FL	28	2
Pensacola	FL	13	1
Atlanta	GA	44	1
Columbus	GA	3	1
Savannah	GA	10	1
Sioux City	IA	2	1
Boise	ID	7	1
Idaho Falls	ID	2	1
Fort Wayne	IN	9	6
Gary	IN	5	2
Indianapolis	IN	31	2
South Bend	IN	6	1
Topeka	KS	4	1
Wichita	KS	16	6
Lexington	KY	27	1
Louisville	KY	14	1
Paducah	KY	6	1
Alexandria	LA	3	1
Baton Rouge	LA	6	3
Houma	LA	3	1
Lafayette	LA	11	2
Metairie	LA	3	2
Shreveport	LA	6	1
Slidell	LA	3	1

HRR City	State	Traditional hospitals	Physician owned hospitals
Royal Oak	MI	5	1
Minneapolis	MN	27	1
Columbia	MO	10	1
Kansas City	MO	29	2
Oxford	MS	3	1
Great Falls	MT	2	1
Missoula	MT	4	1
Charlotte	NC	20	1
Durham	NC	13	1
Lincoln	NE	4	1
Omaha	NE	15	2
Albuquerque	NM	21	3
Akron	OH	3	2
Cincinnati	OH	14	1
Columbus	OH	27	1
Dayton	OH	11	2
Youngstown	OH	7	1
Oklahoma City	OK	27	10
Tulsa	OK	24	4
Eugene	OR	6	1
Allentown	PA	11	2
Erie	PA	8	1
Lancaster	PA	5	1
Philadelphia	PA	30	2
Pittsburgh	PA	32	1
Reading	PA	4	1
York	PA	4	1
Rapid City	SD	2	1
Sioux Falls	SD	12	2
Nashville	TN	35	3
Amarillo	TX	4	1
Austin	TX	14	3
Beaumont	TX	4	1
Bryan	TX	3	1
Corpus Christi	TX	2	1
Dallas	TX	42	19
Fort Worth	TX	22	4
Houston	TX	40	12
Lubbock	TX	10	1
McAllen	TX	4	2
Odessa	TX	2	1
San Antonio	TX	20	3
Tyler	TX	5	1
Wichita Falls	TX	1	1
Ogden	UT	4	1
Salt Lake City	UT	24	2

HRR City	State	Traditional hospitals	Physician owned hospitals
Richmond	VA	15	1
Olympia	WA	2	1
Spokane	WA	12	1
Green Bay	WI	7	1
Milwaukee	WI	23	2
Charleston	WV	9	1
Huntington	WV	2	1
Totals		1230	186

Table 2. Numbers of facilities and discharges for each DRG, separately for POHs and traditional hospitals.

DRG Code	DRG Description		Physician owned hospitals	Traditional hospitals
177	Respiratory infections and inflammations with MCC	Total N discharges	1311	12853
		Total N facilities	43	329
189	Pulmonary edema and respiratory failure	Total N discharges	1913	26106
		Total N facilities	47	458
190	Chronic obstructive pulmonary disease with MCC	Total N discharges	2658	26419
		Total N facilities	62	530
193	Simple pneumonia and pleurisy with MCC	Total N discharges	2547	31509
		Total N facilities	62	560
246	Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries	Total N discharges	1259	5575
		Total N facilities	36	155
247	Percutaneous cardiovascular procedures with drug-eluting stent without MCC	Total N discharges	2441	13105
		Total N facilities	48	266
280	Acute myocardial infarction, discharged alive with MCC	Total N discharges	1885	15710
		Total N facilities	56	370
291	Heart failure and shock with MCC	Total N discharges	6875	93892
		Total N facilities	76	743
454	Combined anterior and posterior spinal fusion with CC	Total N discharges	1317	3612
		Total N facilities	37	105
455	Combined anterior and posterior spinal fusion without CC/MCC	Total N discharges	2212	3961
		Total N facilities	55	137
460	Spinal fusion except cervical without MCC	Total N discharges	4208	12367
		Total N facilities	90	296
468	Revision of hip or knee replacement without CC/MCC	Total N discharges	908	2131
		Total N facilities	38	88
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	Total N discharges	35830	140975
		Total N facilities	152	1020
473	Cervical spinal fusion without CC/MCC	Total N discharges	925	1039
		Total N facilities	33	65
483	Major joint or limb reattachment procedures of upper extremities	Total N discharges	5728	18562
		Total N facilities	103	449
682	Renal failure with MCC	Total N discharges	1548	18618
		Total N facilities	50	374
690	Kidney and urinary tract infections without MCC	Total N discharges	2063	28115
		Total N facilities	57	577

DRG Code	DRG Description		Physician owned hospitals	Traditional hospitals
853	Infectious and parasitic diseases with OR procedures with MCC	Total N discharges	1035	14540
		Total N facilities	39	307
871	Septicemia or severe sepsis without MV >96 hours with MCC	Total N discharges	9285	147533
		Total N facilities	69	686
872	Septicemia or severe sepsis without MV >96 hours without MCC	Total N discharges	1977	33764
		Total N facilities	58	590

Table 3. Demographic characteristics and comorbidity levels among patients in POHs and traditional hospitals. Chi-square tests of significance were performed for age, race, and sex; Welch's t-test was used for the Elixhauser scale.

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
177	Respiratory infections and inflammations with MCC	Age					
			< 65	16.63	13.32	15.67	<0.001
			65-74	23.65	26.04		
			75-84	29.98	28.36		
			85+	29.75	32.28		
		Sex					
			Female	48.89	47.86	0.46	<0.001
			Male	51.11	52.14		
		Race					
			White	81.39	81.52	8.46	<0.001
			Black	8.85	9.58		
			Hisp/Latino	2.06	2.84		
			Other race	7.70	6.06		
		Elix mean		3.14	3.09	-1.26	0.208
189	Pulmonary edema and respiratory failure	Age					
			< 65	21.33	21.21	5.26	<0.001
			65-74	35.81	37.21		
			75-84	29.01	26.79		
			85+	13.85	14.79		
		Sex					
			Female	61.84	58.45	8.31	<0.001
			Male	38.16	41.55		
		Race					
			White	84.58	80.46	20.50	<0.001
			Black	9.83	13.00		
			Hisp/Latino	1.67	1.81		
			Other race	3.92	4.73		
		Elix mean		2.60	2.74	3.69	<0.001

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
190	Chronic obstructive pulmonary disease with MCC	Age					
			< 65	17.38	18.80	10.30	<0.001
			65-74	35.82	37.48		
			75-84	31.41	29.82		
			85+	15.39	13.89		
		Sex					
			Female	60.08	58.07	3.95	<0.001
			Male	39.92	41.93		
		Race					
			White	86.83	83.80	29.27	<0.001
			Black	7.41	10.50		
			Hisp/Latino	1.81	2.26		
			Other race	3.95	3.44		
		Elix mean		2.21	2.19	-0.53	0.599
193	Simple pneumonia and pleurisy with MCC	Age					
			< 65	13.78	16.33	12.76	<0.001
			65-74	30.82	30.74		
			75-84	29.45	28.66		
			85+	25.95	24.27		
		Sex					
			Female	54.77	54.53	0.05	<0.001
			Male	45.23	45.47		
		Race					
			White	84.33	80.89	27.70	<0.001
			Black	7.30	8.94		
			Hisp/Latino	2.59	4.34		
			Other race	5.77	5.83		
		Elix mean		2.70	2.79	2.49	0.013

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
246	Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries	Age					
			< 65	13.50	16.48	18.75	<0.001
			65-74	40.19	42.78		
			75-84	31.06	28.93		
			85+	15.25	11.80		
		Sex					
			Female	40.11	40.47	0.04	<0.001
			Male	59.89	59.53		
		Race					
			White	85.54	82.57	17.56	<0.001
			Black	7.39	9.96		
			Hisp/Latino	1.75	3.16		
			Other race	5.32	4.32		
		Elix mean		2.54	2.81	4.96	<0.001
247	Percutaneous cardiovascular procedures with drug-eluting stent without MCC	Age					
			< 65	10.61	11.32	8.53	<0.001
			65-74	45.06	47.52		
			75-84	33.59	31.06		
			85+	10.73	10.11		
		Sex					
			Female	35.68	36.50	0.56	<0.001
			Male	64.32	63.50		
		Race					
			White	89.92	88.00	13.33	<0.001
			Black	4.55	6.42		
			Hisp/Latino	1.76	1.58		
			Other race	3.77	4.01		
		Elix mean		1.50	1.58	2.61	0.009

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
280	Acute myocardial infarction, discharged alive with MCC	Age					
			<65	13.63	15.43	5.13	<0.001
			65-74	32.36	32.20		
			75-84	28.97	27.37		
			85+	25.04	25.00		
		Sex					
			Female	50.50	48.13	3.69	<0.001
			Male	49.50	51.87		
		Race					
			White	77.98	74.91	14.35	<0.001
			Black	14.27	14.96		
			Hisp/Latino	2.44	3.86		
			Other race	5.31	6.28		
		Elix mean		3.06	3.40	8.25	<0.001
291	Heart failure and shock with MCC	Age					
			< 65	13.08	14.71	15.01	<0.001
			65-74	29.48	28.57		
			75-84	29.63	28.84		
			85+	27.81	27.87		
		Sex					
			Female	50.82	51.96	3.27	<0.001
			Male	49.18	48.04		
		Race					
			White	78.17	73.99	71.05	<0.001
			Black	13.32	16.80		
			Hisp/Latino	3.07	3.80		
			Other race	5.44	5.41		
		Elix mean		3.58	3.70	5.52	<0.001

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
454	Combined anterior and posterior spinal fusion with CC	Age					
			< 65	16.10	15.25	3.06	<0.001
			65-74	59.15	57.70		
			75-84	23.39	25.30		
			85+	1.37	1.74		
		Sex					
			Female	61.66	58.55	3.72	<0.001
			Male	38.34	41.45		
		Race					
			White	89.67	90.03	0.71	<0.001
			Black	5.16	4.79		
			Hisp/Latino	0.61	0.78		
			Other race	4.56	4.40		
		Elix mean		1.64	1.67	0.72	0.470
455	Combined anterior and posterior spinal fusion without CC/MCC	Age					
			< 65	13.20	13.96	6.04	<0.001
			65-74	63.34	60.21		
			75-84	22.06	24.31		
			85+	1.40	1.51		
		Sex					
			Female	52.35	54.30	2.10	<0.001
			Male	47.65	45.70		
		Race					
			White	89.78	91.29	15.35	<0.001
			Black	4.97	3.21		
			Hisp/Latino	0.54	0.98		
			Other race	4.70	4.52		
		Elix mean		1.14	1.00	-4.84	<0.001

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
460	Spinal fusion except cervical without MCC	Age					
			< 65	13.36	15.72	41.97	<0.001
			65-74	57.75	52.14		
			75-84	26.52	29.13		
			85+	2.38	3.01		
		Sex					
			Female	56.32	55.65	0.55	<0.001
			Male	43.68	44.35		
		Race					
			White	91.75	89.66	34.36	<0.001
			Black	3.54	5.83		
			Hisp/Latino	0.78	0.91		
			Other race	3.92	3.60		
		Elix mean		1.22	1.37	7.10	<0.001
468	Revision of hip or knee replacement without CC/MCC	Age					
			< 65	10.57	13.14	11.76	<0.001
			65-74	60.35	54.48		
			75-84	25.55	27.17		
			85+	3.52	5.21		
		Sex					
			Female	55.62	57.48	0.83	<0.001
			Male	44.38	42.52		
		Race					
			White	90.42	88.13	7.30	<0.001
			Black	5.07	6.71		
			Hisp/Latino	0.22	0.89		
			Other race	4.30	4.27		
		Elix mean		1.14	1.05	-2.06	0.040

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	Age					
			< 65	5.46	6.99	1723.18	<0.001
			65-74	60.72	51.18		
			75-84	29.12	31.09		
			85+	4.70	10.75		
		Sex					
			Female	61.53	63.41	43.50	<0.001
			Male	38.47	36.59		
		Race					
			White	91.29	89.35	241.65	<0.001
			Black	3.53	5.46		
			Hisp/Latino	0.76	0.98		
			Other race	4.43	4.21		
		Elix mean		1.17	1.30	19.76	<0.001
473	Cervical spinal fusion without CC/MCC	Age					
			< 65	22.70	23.97	12.61	<0.001
			65-74	60.22	54.67		
			75-84	16.54	19.44		
			85+	0.54	1.92		
		Sex					
			Female	54.59	54.57	0.00	<0.001
			Male	45.41	45.43		
		Race					
			White	88.86	87.58	4.22	<0.001
			Black	6.81	6.93		
			Hisp/Latino	0.65	1.64		
			Other race	3.68	3.85		
		Elix mean		1.02	0.96	-1.33	0.182

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
483	Major joint or limb reattachment procedures of upper extremities	Age					
			< 65	5.64	7.21	46.14	<0.001
			65-74	54.68	51.49		
			75-84	35.11	35.02		
			85+	4.57	6.29		
		Sex					
			Female	57.91	59.14	2.70	<0.001
			Male	42.09	40.86		
		Race					
			White	93.07	92.88	33.50	<0.001
			Black	2.22	3.38		
			Hisp/Latino	0.40	0.47		
			Other race	4.31	3.26		
		Elix mean		1.15	1.27	7.12	<0.001
682	Renal failure with MCC	Age					
			< 65	18.86	17.11	4.75	<0.001
			65-74	29.97	29.21		
			75-84	27.58	28.47		
			85+	23.58	25.21		
		Sex					
			Female	51.49	51.72	0.02	<0.001
			Male	48.51	48.28		
		Race					
			White	71.32	69.14	6.31	<0.001
			Black	18.35	18.65		
			Hisp/Latino	3.94	5.22		
			Other race	6.40	6.99		
		Elix mean		3.94	3.90	-1.06	0.291

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
690	Kidney and urinary tract infections without MCC	Age					
			< 65	10.81	11.44	5.85	<0.001
			65-74	26.13	24.28		
			75-84	33.49	32.81		
			85+	29.57	31.47		
		Sex					
			Female	71.98	71.07	0.74	<0.001
			Male	28.02	28.93		
		Race					
			White	80.27	80.82	10.99	<0.001
			Black	8.53	9.81		
			Hisp/Latino	4.65	4.19		
			Other race	6.54	5.19		
		Elix mean		2.31	2.34	0.98	0.326
853	Infectious and parasitic diseases with OR procedures with MCC	Age					
			< 65	24.54	25.06	4.29	<0.001
			65-74	37.87	38.33		
			75-84	26.96	24.50		
			85+	10.63	12.11		
		Sex					
			Female	48.21	44.98	3.95	<0.001
			Male	51.79	55.02		
		Race					
			White	74.88	71.75	7.22	<0.001
			Black	12.75	15.25		
			Hisp/Latino	5.80	5.34		
			Other race	6.57	7.66		
		Elix mean		3.53	3.59	1.09	0.277

DRG Code	DRG Description			Physician owned hospitals	Traditional hospitals	Test Statistic	p-value
871	Septicemia or severe sepsis without MV >96 hours with MCC	Age					
			< 65	16.44	16.47	2.73	<0.001
			65-74	31.37	30.92		
			75-84	28.91	28.61		
			85+	23.28	24.00		
		Sex					
			Female	51.63	51.37	0.24	<0.001
			Male	48.37	48.63		
		Race					
			White	78.05	77.02	47.29	<0.001
			Black	9.22	11.30		
			Hisp/Latino	5.09	4.34		
			Other race	7.64	7.33		
		Elix mean		3.21	3.23	1.09	0.274
872	Septicemia or severe sepsis without MV >96 hours without MCC	Age					
			< 65	18.36	17.92	0.75	<0.001
			65-74	32.63	33.49		
			75-84	30.05	29.59		
			85+	18.97	18.99		
		Sex					
			Female	55.99	53.21	5.70	<0.001
			Male	44.01	46.79		
		Race					
			White	81.39	79.22	26.66	<0.001
			Black	7.08	8.98		
			Hisp/Latino	6.07	4.53		
			Other race	5.46	7.26		
		Elix mean		2.53	2.55	0.61	0.540

Table 4. Crude comparisons of average paid amounts by DRG in traditional and physician owned hospitals.

		Traditional hospitals			Physician owned hospitals			Differences	
DRG	DRG Description	Mean payment	Number of discharges	Number of facilities	Mean payment	Number of discharges	Number of facilities	Mean payment difference	Percent difference
177	Respiratory infections and inflammations with MCC	$13,168.00	12853	329	$11,404.67	1311	43	$1,763	13.4%
189	Pulmonary edema and respiratory failure	$9,730.10	26106	458	$8,386.55	1913	47	$1,344	13.8%
190	Chronic obstructive pulmonary disease with MCC	$9,088.75	26419	530	$7,760.24	2658	62	$1,329	14.6%
193	Simple pneumonia and pleurisy with MCC	$9,930.46	31509	560	$8,534.96	2547	62	$1,395	14.1%
246	Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries	$23,384.09	5575	155	$20,473.08	1259	36	$2,911	12.4%
247	Percutaneous cardiovascular procedures with drug-eluting stent without MCC	$15,250.00	13105	266	$13,209.82	2441	48	$2,040	13.4%
280	Acute myocardial infarction, discharged alive with MCC	$12,912.44	15710	370	$10,484.35	1885	56	$2,428	18.8%
291	Heart failure and shock with MCC	$10,426.71	93892	743	$8,573.01	6875	76	$1,854	17.8%

		Traditional hospitals			Physician owned hospitals			Differences	
DRG	DRG Description	Mean payment	Number of discharges	Number of facilities	Mean payment	Number of discharges	Number of facilities	Mean payment difference	Percent difference
454	Combined anterior and posterior spinal fusion with CC	$50,190.24	3612	105	$40,826.29	1317	37	$9,364	18.7%
455	Combined anterior and posterior spinal fusion without CC/MCC	$38,454.47	3961	137	$31,932.94	2212	55	$6,522	17.0%
460	Spinal fusion except cervical without MCC	$30,055.65	12367	296	$24,860.04	4208	90	$5,196	17.3%
468	Revision of hip or knee replacement without CC/MCC	$21,110.67	2131	88	$17,064.63	908	38	$4,046	19.2%
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	$14,655.22	140975	1020	$12,336.71	35830	152	$2,319	15.8%
473	Cervical spinal fusion without CC/MCC	$17,918.28	1039	65	$14,452.57	925	33	$3,466	19.3%
483	Major joint or limb reattachment procedures of upper extremities	$17,305.34	18562	449	$14,731.96	5728	103	$2,573	14.9%
682	Renal failure with MCC	$11,463.52	18618	374	$9,772.06	1548	50	$1,691	14.8%
690	Kidney and urinary tract infections without MCC	$6,508.79	28115	577	$5,608.81	2063	57	$900	13.8%

		Traditional hospitals			Physician owned hospitals			Differences	
DRG	DRG Description	Mean payment	Number of discharges	Number of facilities	Mean payment	Number of discharges	Number of facilities	Mean payment difference	Percent difference
853	Infectious and parasitic diseases with OR procedures with MCC	$38,334.41	14540	307	$32,540.65	1035	39	$5,794	15.1%
871	Septicemia or severe sepsis without MV >96 hours with MCC	$14,165.61	147533	686	$12,729.31	9285	69	$1,436	10.1%
872	Septicemia or severe sepsis without MV >96 hours without MCC	$8,513.41	33764	590	$7,463.53	1977	58	$1,050	12.3%

Table 5. Results from mixed effects regression models regressing total payments on POH status controlling for patient demographics and comorbidities, by DRG.

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
177	Respiratory infections and inflammations with MCC	(Intercept)	9.388	0.024	393.57	<0.001
		Black	0.030	0.009	3.23	0.001
		Hispanic	0.036	0.017	2.12	0.034
		Other	0.001	0.011	0.13	0.898
		Male	0.011	0.005	1.99	0.046
		Age <65	0.048	0.009	5.30	<0.001
		Age 75-84	-0.037	0.007	-5.10	<0.001
		Age 85+	-0.059	0.007	-8.26	<0.001
		Comorbidity scale	0.011	0.002	6.62	<0.001
		POH	-0.092	0.009	-10.01	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
189	Pulmonary edema and respiratory failure	(Intercept)	9.090	0.022	419.91	<0.001
		Black	0.056	0.006	9.93	<0.001
		Hispanic	0.058	0.014	4.19	<0.001
		Other	-0.018	0.009	-2.07	0.039
		Male	0.024	0.004	6.59	<0.001
		Age <65	-0.002	0.005	-0.31	0.757
		Age 75-84	-0.022	0.004	-4.82	<0.001
		Age 85+	-0.025	0.005	-4.55	<0.001
		Comorbidity scale	0.009	0.001	8.35	<0.001
		POH	-0.108	0.007	-14.81	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
190	Chronic obstructive pulmonary disease with MCC	(Intercept)	9.038	0.022	408.90	<0.001
		Black	0.059	0.007	8.54	<0.001
		Hispanic	0.027	0.014	1.91	0.056
		Other	-0.032	0.012	-2.77	0.006
		Male	0.009	0.004	2.23	0.026
		Age <65	0.015	0.006	2.64	0.008
		Age 75-84	-0.006	0.005	-1.32	0.188
		Age 85+	-0.026	0.006	-4.16	<0.001
		Comorbidity scale	0.006	0.001	4.78	<0.001
		POH	-0.129	0.007	-18.13	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
193	Simple pneumonia and pleurisy with MCC	(Intercept)	9.135	0.019	471.95	<0.001
		Black	0.034	0.006	5.67	<0.001
		Hispanic	0.029	0.008	3.47	<0.001
		Other	0.001	0.007	0.19	0.849
		Male	0.010	0.003	3.02	0.003
		Age <65	0.018	0.005	3.67	<0.001
		Age 75-84	-0.027	0.004	-6.48	<0.001
		Age 85+	-0.037	0.004	-8.52	<0.001
		Comorbidity scale	0.008	0.001	7.74	<0.001
		POH	-0.118	0.006	-18.92	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
246	Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries	(Intercept)	9.988	0.021	485.92	<0.001
		Black	0.032	0.013	2.42	0.016
		Hispanic	0.059	0.024	2.43	0.015
		Other	0.027	0.018	1.52	0.130
		Male	0.027	0.008	3.58	<0.001
		Age <65	-0.001	0.011	-0.09	0.929
		Age 75-84	-0.036	0.009	-4.01	<0.001
		Age 85+	-0.054	0.012	-4.45	<0.001
		Comorbidity scale	0.004	0.002	1.63	0.103
		POH	-0.133	0.010	-12.69	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
247	Percutaneous cardiovascular procedures with drug-eluting stent without MCC	(Intercept)	9.592	0.019	493.83	<0.001
		Black	0.056	0.010	5.65	<0.001
		Hispanic	0.059	0.019	3.19	0.001
		Other	0.027	0.012	2.36	0.018
		Male	0.022	0.005	4.50	<0.001
		Age <65	-0.015	0.008	-1.88	0.060
		Age 75-84	-0.058	0.005	-10.88	<0.001
		Age 85+	-0.081	0.008	-10.25	<0.001
		Comorbidity scale	0.004	0.002	2.49	0.013
		POH	-0.117	0.007	-16.96	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
280	Acute myocardial infarction, discharged alive with MCC	(Intercept)	9.310	0.022	426.30	<0.001
		Black	0.053	0.007	7.06	<0.001
		Hispanic	0.063	0.014	4.49	<0.001
		Other	0.002	0.011	0.20	0.839
		Male	0.010	0.005	1.94	0.053
		Age <65	0.025	0.008	3.20	0.001
		Age 75-84	-0.015	0.006	-2.35	0.019
		Age 85+	-0.033	0.007	-4.87	<0.001
		Comorbidity scale	0.011	0.001	7.47	<0.001
		POH	-0.148	0.008	-17.49	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
291	Heart failure and shock with MCC	(Intercept)	9.136	0.018	506.29	<0.001
		Black	0.064	0.003	22.15	<0.001
		Hispanic	0.045	0.005	8.25	<0.001
		Other	0.013	0.005	2.77	0.006
		Male	0.013	0.002	6.48	<0.001
		Age <65	0.024	0.003	7.36	<0.001
		Age 75-84	-0.021	0.003	-7.89	<0.001
		Age 85+	-0.043	0.003	-16.15	<0.001
		Comorbidity scale	0.009	0.001	15.50	<0.001
		POH	-0.143	0.004	-35.02	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
454	Combined anterior and posterior spinal fusion with CC	(Intercept)	10.704	0.024	443.37	<0.001
		Black	-0.083	0.020	-4.17	<0.001
		Hispanic	0.062	0.056	1.11	0.267
		Other	0.055	0.020	2.68	0.007
		Male	0.029	0.009	3.36	<0.001
		Age <65	0.042	0.012	3.41	<0.001
		Age 75-84	-0.043	0.010	-4.12	<0.001
		Age 85+	-0.094	0.034	-2.74	0.006
		Comorbidity scale	0.005	0.003	1.60	0.109
		POH	-0.141	0.011	-12.67	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
455	Combined anterior and posterior spinal fusion without CC/MCC	(Intercept)	10.483	0.022	484.60	<0.001
		Black	0.017	0.018	0.94	0.345
		Hispanic	-0.006	0.042	-0.15	0.884
		Other	-0.003	0.016	-0.18	0.858
		Male	0.011	0.007	1.54	0.123
		Age <65	0.035	0.010	3.39	<0.001
		Age 75-84	-0.058	0.008	-7.07	<0.001
		Age 85+	-0.049	0.028	-1.74	0.081
		Comorbidity scale	0.002	0.003	0.74	0.459
		POH	-0.120	0.008	-14.94	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
460	Spinal fusion except cervical without MCC	(Intercept)	10.238	0.015	706.07	<0.001
		Black	0.025	0.009	2.68	0.007
		Hispanic	-0.066	0.023	-2.81	0.005
		Other	0.040	0.011	3.61	<0.001
		Male	0.009	0.004	2.13	0.033
		Age <65	0.030	0.006	4.85	<0.001
		Age 75-84	-0.038	0.005	-7.79	<0.001
		Age 85+	-0.056	0.013	-4.37	<0.001
		Comorbidity scale	0.004	0.002	2.61	0.009
		POH	-0.132	0.006	-23.54	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
468	Revision of hip or knee replacement without CC/MCC	(Intercept)	9.870	0.020	505.17	<0.001
		Black	-0.006	0.020	-0.32	0.746
		Hispanic	-0.060	0.059	-1.01	0.310
		Other	0.028	0.024	1.17	0.244
		Male	0.022	0.009	2.39	0.017
		Age <65	0.091	0.015	6.24	<0.001
		Age 75-84	-0.032	0.011	-2.92	0.003
		Age 85+	-0.028	0.022	-1.24	0.217
		Comorbidity scale	-0.003	0.004	-0.74	0.457
		POH	-0.165	0.011	-15.59	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	(Intercept)	9.545	0.011	832.50	<0.001
		Black	0.050	0.003	18.71	<0.001
		Hispanic	0.016	0.006	2.60	0.009
		Other	0.016	0.003	5.57	<0.001
		Male	0.015	0.001	12.30	<0.001
		Age <65	0.025	0.002	10.56	<0.001
		Age 75-84	-0.051	0.001	-39.00	<0.001
		Age 85+	-0.050	0.002	-24.81	<0.001
		Comorbidity scale	0.001	0.000	2.96	0.003
		POH	-0.165	0.002	-102.17	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
473	Cervical spinal fusion without CC/MCC	(Intercept)	9.746	0.024	404.57	<0.001
		Black	0.009	0.023	0.40	0.687
		Hispanic	-0.029	0.063	-0.47	0.641
		Other	-0.012	0.035	-0.35	0.727
		Male	-0.022	0.012	-1.91	0.056
		Age <65	0.021	0.014	1.49	0.135
		Age 75-84	-0.049	0.015	-3.19	0.001
		Age 85+	0.021	0.051	0.40	0.688
		Comorbidity scale	-0.007	0.006	-1.32	0.188
		POH	-0.154	0.013	-12.02	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
483	Major joint or limb reattachment procedures of upper extremities	(Intercept)	9.718	0.014	692.18	<0.001
		Black	0.024	0.008	2.90	0.004
		Hispanic	-0.018	0.021	-0.87	0.387
		Other	0.003	0.008	0.33	0.744
		Male	0.018	0.003	6.18	<0.001
		Age <65	0.052	0.006	8.78	<0.001
		Age 75-84	-0.032	0.003	-10.27	<0.001
		Age 85+	-0.032	0.006	-5.05	<0.001
		Comorbidity scale	0.001	0.001	0.56	0.575
		POH	-0.156	0.004	-41.61	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
682	Renal failure with MCC	(Intercept)	9.220	0.025	366.01	<0.001
		Black	0.053	0.007	8.09	<0.001
		Hispanic	0.015	0.011	1.36	0.174
		Other	0.028	0.010	2.90	0.004
		Male	0.007	0.005	1.48	0.139
		Age <65	0.036	0.007	4.89	<0.001
		Age 75-84	-0.029	0.006	-4.62	<0.001
		Age 85+	-0.047	0.007	-7.22	<0.001
		Comorbidity scale	0.012	0.002	7.56	<0.001
		POH	-0.097	0.009	-10.59	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
690	Kidney and urinary tract infections without MCC	(Intercept)	8.711	0.021	421.73	<0.001
		Black	0.062	0.006	11.16	<0.001
		Hispanic	0.069	0.009	7.93	<0.001
		Other	0.070	0.008	9.09	<0.001
		Male	0.003	0.004	0.77	0.441
		Age <65	0.045	0.006	7.81	<0.001
		Age 75-84	-0.018	0.004	-4.16	<0.001
		Age 85+	-0.034	0.004	-7.86	<0.001
		Comorbidity scale	0.005	0.001	4.32	<0.001
		POH	-0.127	0.007	-19.52	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
853	Infectious and parasitic diseases with OR procedures with MCC	(Intercept)	10.306	0.029	354.25	<0.001
		Black	0.043	0.011	3.98	<0.001
		Hispanic	-0.041	0.017	-2.41	0.016
		Other	-0.001	0.014	-0.09	0.929
		Male	0.038	0.007	5.27	<0.001
		Age <65	0.037	0.010	3.85	<0.001
		Age 75-84	-0.042	0.009	-4.46	<0.001
		Age 85+	-0.087	0.012	-7.28	<0.001
		Comorbidity scale	0.016	0.002	6.96	<0.001
		POH	-0.104	0.015	-7.02	<0.001

DRG	DRG Description	Covariate	Value	Standard Error	t-value	p-value
871	Septicemia or severe sepsis without MV >96 hours with MCC	(Intercept)	9.433	0.019	506.96	<0.001
		Black	0.054	0.003	18.90	<0.001
		Hispanic	0.037	0.004	8.42	<0.001
		Other	0.016	0.003	4.73	<0.001
		Male	0.014	0.002	8.46	<0.001
		Age <65	0.032	0.003	12.16	<0.001
		Age 75-84	-0.032	0.002	-14.46	<0.001
		Age 85+	-0.055	0.002	-23.61	<0.001
		Comorbidity scale	0.010	0.001	18.81	<0.001
		POH	-0.090	0.004	-24.14	<0.001
DRG	**DRG Description**	**Covariate**	**Value**	**Standard Error**	**t-value**	**p-value**
872	Septicemia or severe sepsis without MV >96 hours without MCC	(Intercept)	8.969	0.018	490.91	<0.001
		Black	0.084	0.006	14.51	<0.001
		Hispanic	0.061	0.008	7.62	<0.001
		Other	0.058	0.006	9.00	<0.001
		Male	0.001	0.003	0.41	0.681
		Age <65	0.016	0.005	3.35	<0.001
		Age 75-84	-0.049	0.004	-12.12	<0.001
		Age 85+	-0.055	0.005	-12.06	<0.001
		Comorbidity scale	0.003	0.001	3.14	0.002
		POH	-0.096	0.007	-13.48	<0.001

Table 6. Estimated differences in payments in POHs and traditional hospitals, by DRG.

DRG	DRG Description	Mean payment difference POHs vs. traditional hospitals **	Percent difference
177	Respiratory infections and inflammations with MCC	-$1,090	-8.8%
189	Pulmonary edema and respiratory failure	-$926	-10.2%
190	Chronic obstructive pulmonary disease with MCC	-$1,036	-12.1%
193	Simple pneumonia and pleurisy with MCC	-$1,057	-11.2%
246	Percutaneous cardiovascular procedures with drug-eluting stent with MCC or 4+ arteries	-$2,729	-12.4%
247	Percutaneous cardiovascular procedures with drug-eluting stent without MCC	-$1,623	-11.0%
280	Acute myocardial infarction, discharged alive with MCC	-$1,582	-13.8%
291	Heart failure and shock with MCC	-$1,275	-13.3%
454	Combined anterior and posterior spinal fusion with CC	-$5,925	-13.2%
455	Combined anterior and posterior spinal fusion without CC/MCC	-$4,053	-11.3%
460	Spinal fusion except cervical without MCC	-$3,469	-12.3%

DRG	DRG Description	Mean payment difference POHs vs. traditional hospitals **	Percent difference
468	Revision of hip or knee replacement without CC/MCC	-$2,931	-15.2%
470	Major hip and knee joint replacement or reattachment of lower extremity without MCC	-$2,128	-15.2%
473	Cervical spinal fusion without CC/MCC	-$2,419	-11.2%
483	Major joint or limb reattachment procedures of upper extremities	-$2,405	-14.3%
682	Renal failure with MCC	-$975	-14.5%
690	Kidney and urinary tract infections without MCC	-$734	-9.2%
853	Infectious and parasitic diseases with OR procedures with MCC	-$3,127	-12.0%
871	Septicemia or severe sepsis without MV >96 hours with MCC	-$1,105	-9.9%
872	Septicemia or severe sepsis without MV >96 hours without MCC	-$726	-8.6%

** Reference levels for these calculations were White, females, aged 65-74 at the average level of comorbidities for each DRG.

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Statement for the Record

Subcommittee on Health of the Committee on Energy and Commerce
Examining Medicare Proposals to Improve Patient Access to Care and Minimize Red Tape for Doctors

October 19, 2023

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 subcommittee's interest in improving patient access to care, minimizing red tape for physicians, and to convey our staunch support for several pieces of legislation before the subcommittee.

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 and families have access to coverage and high-quality care when and where they need it. As such, the AOA unequivocally believes that the primary focus of any potential policy or legislative change should be to expand, or at minimum, maintain access to comprehensive high-quality care at the appropriate time and setting. It is with these sentiments that we express our support for the following legislations.

Patient Access to Care

The ***Saving Access to Laboratory Services Act (SALSA)*** **is an essential bipartisan, bicameral legislation, which provides critical updates to Medicare's payment system for laboratory services – supporting earlier disease detection and improved patient care.**

Between 2017-2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent. An additional 15 percent cut, for nearly 800 common laboratory tests, is scheduled to take effect January 1, 2024. These drastic payment cuts jeopardize access to many clinical laboratory tests that are used to diagnose, monitor, prevent, and manage common diseases impacting Medicare beneficiaries. The impact of these cuts will be felt hardest by small independent physician practices that offer in-house laboratory services but may no longer be able to sustain such services following further payment cuts. In addition to cuts to the laboratory services, physicians are also facing a payment reduction in the proposed CY24 Medicare Physician Fee Schedule, as the cost of maintaining an independent practice and providing care soars. The closure of these practices because of additional and compounding payment cuts would most significantly impact rural and underserved communities already facing difficulties accessing care.

A strong, national laboratory infrastructure is essential for the rapid development and distribution of tests, particularly for common diseases and new pathogens. The enactment of *SALSA* would address years of Medicare payment cuts to clinical laboratory services and provide a payment system that is stable and sustainable.

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We are also grateful for the subcommittee's continued efforts to reform prior authorization in the Medicare Advantage (MA) program. The *Improving Seniors Timely Access to Care Act* would help address many of the problems patients and physicians are experiencing in the prior authorization process.

Any change to improve prior authorization should be designed with the end goal of reducing patients' wait times for treatment, reducing physician administrative burden, and allowing physicians to spend more time with patients. We, therefore, greatly appreciate the Subcommittee's continued efforts to ensure MA policies are not a barrier to timely and equitable access to care for the patients our members serve. Congress can protect our nation's seniors from wrongfully delayed or denied care by requiring proper transparency and oversight of prior authorization in the MA program. If adopted, **the *Improving Seniors Timely Access to Care Act* will reduce barriers to care, decrease provider burden, and help ensure Medicare beneficiaries enrolled in MA plans have the same access to Medicare-covered items and services as beneficiaries who opt for traditional Medicare.**

Independent Practice Sustainability

The healthcare system is experiencing unprecedented consolidation, amongst both hospitals and physician practices – contributing to the workforce shortage, and driving up costs, without improving quality of care for patients. For example, in 2020, the Medicare Payment Advisory Commission, or MedPAC, released a report[1] concluding that "the preponderance of evidence suggests that hospital consolidation leads to higher prices." In addition, a study conducted by the University of Chicago Law School[2] found that physicians in the most concentrated markets throughout the country charged patients 14% to 30% more than practices in the least concentrated markets. Another study that examined Medicare beneficiaries' patterns of health care utilization found that acquisition of primary care practices by larger hospitals and health systems led to increased utilization and a 5% increase in enrollee spending without considerable changes in quality.[3] Simply put, consolidation does not improve quality of care and drives up costs for patients. It is essential that action is taken to support small and independent practices, and that physicians are able to provide patients with the high-quality care they are trained to deliver, regardless of their practice setting or employment model. In the long-term, comprehensive reform of the Quality Payment Program is necessary to support value-based payment and ensure that providers across settings are treated equitably. However, several short-term actions can provide more immediate, necessary support to physician practices.

The AOA urges the subcommittee to support the passage of the *SURS Extension Act*. The Quality Payment Program's Small Practice, Underserved, and Rural Support (QPP-SURS) program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access to care while lowering costs. Most small and rural physician practices do not have access to the technical or administrative staff or funding necessary to ensure proper participation in the Merit-based Incentive Payment System (MIPS), which currently disadvantages small and independent physician practices. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering

[1] MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy," March 13, 2020.
[2] Dunn, Abe and Shapiro, Adam Hale (2014) "Do Physicians Possess Market Power?," *Journal of Law and Economics*: Vol. 57: No. 1, Article 6.
[3] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. J Health Econ. 2018 May

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demonstrably better quality of care[4]. Physician-owned practices deliver high-quality, cost-effective care regardless of health system affiliation, and this research demonstrates that small and independent practices are being unfairly disadvantaged due to their inability to make the same investments in technical infrastructure and administrative support as compared to larger enterprises.

In addition to funding the QPP-SURS program to provide technical assistance to practices, we encourage the Committee to support practices in making the necessary investments to participate in alternative payment models. For this reason, the AOA strongly supports extending incentive payments for participation in eligible alternative payment models. Ensuring physicians in small and independent practices can participate in payment models that incentivize high-quality, cost-effective care is integral in supporting the physician workforce in our rural and underserved communities.

The Energy and Commerce Committee has said it will review inequities resulting from the area wage index and the geographic practice cost index (GPCI), which is an excellent starting point for review of unique challenges long impacting rural communities. **We highly encourage the subcommittee to extend the 1.0 work GPCI floor.** According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI values raised by the floor to the national average. Without congressional action, the expiration of GPCI floor, established by Congress, will greatly impact rural communities that tend to have more patients in medically underserved areas.[5]

In testimony to the Ways & Means Committee in 2002, Urban Institute economists argued that the GPCI should account for more than just cost of living in order to promote adequate supply of physicians in both urban and rural areas.[6] Economists recognized at the time that a decision to not include secondary factors impacting the economic feasibility of rural physician practices could damage the sustainability of the rural physician workforce. Equalization of real compensation has not happened in the ensuing 21 years, and rural areas face increasingly severe physician shortages.

The AOA would also like to convey our support for the *Provider Reimbursement Stability Act*, which would make the following changes to the Medicare Physician Fee Schedule (MPFS) with the goal of promoting sustainability in reimbursement and ensuring continued access to high quality healthcare: (1) increasing the threshold for applying budget neutrality from $20 million to $53 million to reflect the increase in the Medicare Economic Index (MEI) since the threshold was last updated, (2) require CMS to reconcile any overestimates and underestimates of pricing adjustment and make corresponding payment, and (3) updating prices for direct expenses related to budget neutrality adjustments with the goal of more frequently and accurately updating the costs used to calculate the Relative Value Units (RVUs) that are used to calculate the reimbursement formula for physician services.

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[4] Johnston 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;324(10):984-992*

[5] Government Accountability Office. "Information on Geographic Adjustments to Physician Payments for Physicians' Time, Skills, and Effort." 2022

[6] Urban Institute. "Just Why Do We Adjust Medicare Physician Fees for Geographic Practice Cost Differences?" 2002.

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In addition to these legislations being considered by the subcommittee, **the AOA strongly encourages the committee to consider advancing the *Strengthening Medicare for Patients and Providers Act*, and the *Resident Education Deferred Interest (REDI) Act.***

To address the economic disparities across geographic areas, Congress must implement sustainable adjustments to the MPFS such as tie-ins to the Medicare Economic Index (MEI), which was a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC) for 2024.[7] **Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update.** This change 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 committee to support this legislation.

Ensuring a Stable Workforce of Physicians Serving Medicare Beneficiaries

Substantial student loan debt and year over year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. **AOA strongly urges the Committee to consider the *Resident Education Deferred Interest Act* (REDI Act), H.R. 1202.** The REDI Act would allow resident physicians to defer student loan interest from medical school until the completion of their residency. Medical school graduates must undertake several years of residency with a modest salary[8] and are often unable to begin repaying student debt immediately. While these medical residents are eligible to have payments halted during residency, the debt still accrues interest, causing ballooning balances for many borrowers. The REDI Act would reduce student debt burden without direct forgiveness or reducing the borrower's original balance.

Reducing the total debt burden for physicians completing residencies would enable physicians to have more flexibility in where they choose to practice. The combined impact of substantial student loan debt and year-over-year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. In recent years, the ratio of physicians to Medicare beneficiaries has declined among both primary care and specialists.[9] While most Medicare beneficiaries may not currently report acute access challenges, as suggested by MedPAC, this is quickly changing as the Medicare-eligible population grows and the physician workforce does not keep pace.

A recent AAMC report suggests that the physician workforce shortage will grow to between 37,800 and 124,000 physicians by 2034.[10] In light of this looming shortage, it is essential that steps are taken to preserve access to care across the country, especially for Medicare beneficiaries. For this reason, we urge you to support the ***Resident Physician Shortage Reduction Act, H.R. 2389.*** This legislation would create up to 2,000 new GME slots per year for seven years, prioritizing rural areas, health professional shortage areas, and historically underserved settings, including hospitals affiliated with historically black medical schools. Comprehensive efforts are needed to ensure a stable physician workforce that can care for our country's growing Medicare population.

[7] MedPAC. "March 2023 Report to the Congress: Medicare Payment Policy." 2023.
[8] https://www.aamc.org/data-reports/students-residents/report/aamc-survey-resident/fellow-stipends-and-benefits
[9] MedPAC March 2023 Report to Congress: Medicare Payment Policy." 2023.
[10] American Association of Medical Colleges. "The Complexities of Physician Supply and Demand: Projections From 2019 to 2034." 2021.

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Again, thank you for the opportunity to submit comments for the record. 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 President of Congressional Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

October 16, 2023

The Honorable Cathy McMorris Rodgers
Chair
House Energy and Commerce Committee
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
Washington, DC 20515

The Honorable Brett Guthrie
Chair, Health Subcommittee
House Energy and Commerce Committee
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member, Health Subcommittee
House Energy and Commerce Committee
Washington, DC 20515

Dear Chairwoman McMorris Rodgers, Chairman Guthrie and Ranking Members Pallone and Eshoo:

On behalf of the undersigned organizations, a coalition of national medical societies, representing a broad range of physicians, health professionals and practice managers who care for Medicare beneficiaries in a community-based, office setting, **we respectfully urge the Committee to begin discussions regarding the inclusion of policies to mitigate forthcoming Medicare reimbursement cuts. Absent action by Congress, physicians again face substantial payment reductions as of January 1, 2024.**

For more than twenty years, Medicare payments to physicians have been under pressure due to budget neutrality methodology and lack of anti-inflation payment policies contained in their fee schedule. While physician services represent a very modest portion of the overall growth in healthcare and the subsection attributed to Medicare spending, they are perennial targets for payment cuts when policymakers seek to control overall and healthcare spending.

For CY 2024, the conversion factor (CF) proposed by the Centers for Medicare & Medicaid Services (CMS) based on current law is $32.75, a decrease of $1.14, or 3.34%, from CY 2023. The impact of these overall Medicare PFS reductions is disproportionate across the provider community, with many specialties anticipating even greater reductions due to the third year of the phased in implementation of the CMS clinical labor pricing update, which was finalized in the CY2022 MPFS Final Rule. The impact of these cuts is real for physicians who care for Medicare beneficiaries in a community-based, office setting, and will increasingly result in diminished access to care for Medicare patients seeking a variety of critical services in their neighborhood. Community-based, care in an office setting is a critical part of the nation's healthcare infrastructure, and we are certain CMS' reimbursement policy will have repercussions for the future, impacting access and value. Many of these providers are left asking themselves "Where, how, and when will I be able to care for my patients?" Burnout is real. CMS continues to ask physicians and their staff to do more with less.

To avoid significant disruptions in patient access to care, Congress must act before the end of the year to mitigate scheduled payment reductions. Our organizations urge you to include the following provisions in any viable legislative package before the end of the year:

- **H.R. 3674, the "Providing Relief and Stability for Medicare Patients Act of 2023,"** which would increase the non-facility/office-based practice expense relative value units (NF PE RVUs) negatively impacted by CMS' clinical labor policy for the next two years; and
- **H.R. 2474, the "Strengthening Medicare for Patients and Providers Act,"** legislation to provide annual inflationary updates, based on the Medicare Economic Index (MEI), for Medicare physician services, similar to updates received by other health care providers.

This instability in the MPFS is being driven by a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, perennial lack of inflationary updates, and growing administrative burdens. The discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is incentivizing market consolidation.

While work must begin in earnest to permanently reform the Medicare physician payment system and break the cycle of annual payment reductions, Congress must also ACT NOW to fortify current physician practices. Absent action by Congress, the likely result will be providers leaving the field (either through retirement or career adjustment), practices being closed or sold, and a significant number of patients losing access to a variety of healthcare service in their communities.

Moving forward, our organizations look forward to partnering with the Committee to identify policies to reform the Medicare physician payment system, and to specifically protect against policy updates that generate disproportionate payment reductions across the provider community.

Sincerely,

Alliance of Wound Care Stakeholders
American Association of Clinical Urologists
American College of Cardiology
American College of Radiation Oncology
American College of Radiology
American College of Surgeons
American Society for Radiation Oncology
American Society of Diagnostic and Interventional Nephrology
American Society of Nephrology
American Urological Association
American Vein & Lymphatic Society

American Venous Forum
Association of Freestanding Radiation Oncology Centers
CardioVascular Coalition
Dialysis Vascular Access Coalition
Free From Fibroids Foundation
Large Urology Group Practice Association
Outpatient Endovascular and Interventional Society
Renal Physicians Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Interventional Radiology
The US Oncology Network
United Specialists for Patient Access

Cc: The Honorable Gus Bilirakis
The Honorable Tony Cardenas
The Honorable Greg Murphy, MD
The Honorable Danny Davis

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October 19, 2023

The Honorable Brett Guthrie
Chair, Health Subcommittee
House Energy and Commerce Committee
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Anna Eshoo
Ranking Member, Health Subcommittee
House Energy and Commerce Committee
272 Cannon House Office Building
Washington, DC 20515

Dear Chairman Guthrie and Ranking Member Eshoo:

The Society for Vascular Surgery (SVS) is pleased to provide this Statement for the Record regarding the House Energy and Commerce Health Subcommittee's hearing on "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors."

The SVS is comprised of over 6,300 specialty trained vascular surgeons and other medical professionals who are dedicated to the prevention, longitudinal management and cure of vascular disease. As a professional medical specialty society, we seek to advance excellence and innovation in vascular health through education, advocacy, research, and public awareness. Vascular surgeons dedicate their training to addressing the full spectrum of vascular health and disease and as the only specialists board-certified in vascular surgery, they are patient and disease focused. They provide patient-centered care plans with a comprehensive approach, including: prevention, risk factor modification, medical therapy, multiple interventional (endovascular and open surgical) options, and ongoing, chronic disease management. Given the natural intersection between vascular disease and an increasingly aging population, vascular surgeons (and the SVS) are poised to play an important role to ensure the delivery of high-quality longitudinal care for Medicare beneficiaries.

Unfortunately, the ongoing instability in the Medicare Physician Fee Schedule (PFS) due to statutory payment cuts, perennial lack of inflationary updates, significant administrative barriers, and the cumulative impact of the pandemic is causing fiscal uncertainties for physician practices. The discrepancy between what it costs to run a physician practice and actual reimbursements/payments combined with the administrative and cost burden of participating in Medicare is causing/incentivizing market consolidation. To that end, the SVS appreciates the Committee's leadership in proactively working to identify legislative policy solutions designed to fortify the strength of physician practices now, while simultaneously working to reform the Medicare physician payment system for the future. We look forward to collaborating with the Committee to achieve these goals and offer the following comments related to legislation slated for consideration at this hearing.

H.R. 3674, the Providing Relief and Stability for Medicare Patients Act of 2023

As a result of budget-neutrality, the 2021 PFS Proposed Rule contained a reduction in the 2021 conversion factor of nearly 10% due to the initial revaluation of payments for evaluation and management codes and the creation of a new "complexity" code. In recognition of the severity of these cuts and the significant impact on physician practices, Congress delayed implementation of the new add-on code (until 2024) and provided some additional relief through adjustments for the Medicare conversation factor for each of the following years CY2021 (+3.75%),CY2022 (+3%), CY2023 (+2.5%) and CY 2024 (+1.25%). Despite Congress' efforts, physicians have, or will, still absorb payment reductions in each of these years due to implementation of other CMS finalized policies that generate budget neutrality adjustments as part of the annual PFS rulemaking cycle.

Specifically, there are practice expense relative value unit (RVUs)cuts to office-based specialists, due to the adjustment CMS made for clinical labor costs, which results in some services being subject to additional, cumulative cuts in 2023 of 9%. This is due to a 2022 PFS policy which updated 20-year-old clinical labor wage data used as part of the calculation of direct practice expense relative value units in the PFS. There will be additional cuts to practice expense RVUs in the office site of service in 2024 and 2025, unless Congress acts.

Unfortunately, the required application of budget neutrality within the direct practice expense calculation has resulted in office-based specialists seeing their reimbursement for certain codes with high costs supplies and equipment decrease by well over double digit amounts through 2025, separate and apart from any conversion factor cuts.

Office-based specialty care is a critical service outside of the hospital setting. These specialists provide a wide range of services to patients with cancer, end-stage renal disease, eye disease, fibroids, as well as limb salvage and venous ulcer needs. The office setting is also critical for patient access (especially in rural and underserved areas) and can result in patients receiving care sooner.

To avoid significant disruptions in patient access to care, Representatives Gus Bilirakis (R-FL-12), Rep. Tony Cardenas (D-CA-29), Greg Murphy, MD (R-NC-3), and Danny Davis (D-IL-7) introduced H.R. 3674, the Providing Relief and Stability for Medicare Patients Act of 2023, which would mitigate cuts to office-based specialists for a targeted group of services for two years. To achieve this goal, H.R. 3674 would:

- Target/identify "Specified Non-Facility Services," (i.e. office-based services) where at least 65%of the "direct costs" associated with "practice expense relative value units" are comprised of supplies and equipment;
- Increase office-based PE RVUs for "specified non-facility services" by 10% in CY 2024, and 15% in CY 2025;
- Follow existing precedent via implementation at the Contractor level, not unlike the Primary Care Bonus from the ACA or the Imaging Payment Policies from previously passed legislation;
- Include a provision to exempt this policy from budget neutrality so primary care and others can continue to receive increases under the clinical labor update policy; and

- Study the impacts of regulatory changes within the PFS on provider consolidation and patient access to care.

The impact of these cuts is real for physicians who care for Medicare beneficiaries in a community-based, office setting, and will increasingly result in diminished access to care for Medicare patients seeking a variety of critical services in their neighborhood. The SVS is a strong supporter of H.R. 3674 and commends Reps. Bilirakis, Cardenas, Murphy, and Davis for their bipartisan leadership to provide stability for physicians disproportionately impacted by CMS' clinical labor update. We urge Committee and House Leadership to advance H.R. 3674 before the end of the year.

The Provider Reimbursement Stability Act of 2023 (Discussion Draft)

For more than twenty years, Medicare payments have been under pressure from the Centers for Medicare & Medicaid Services (CMS) anti-inflationary payment policies. While physician services represent a very modest portion of the overall growth in spending, they are perennial targets for cuts when policymakers seek to control spending. Although Congress repeatedly intervened to prevent reimbursement cuts to surgeons, anesthesiologists, and other physicians due to the sustainable growth rate (SGR) system — which was enacted in 1997 and repealed in 2015 — Medicare physician payments have remained constrained due to a budget-neutral financing system, and updates to the conversion factor (CF), a critical factor for calculating Medicare payment, have failed to keep up with inflation.

The year-over-year cycle of payment cuts (despite soaring inflation) is a clear indicator that the Medicare physician payment system is broken. Systemic issues such as the negative impact of the Medicare physician fee schedule's budget neutrality requirements and the lack of an annual inflationary update will continue to generate significant instability for clinicians, threatening beneficiary access to essential health care services. Policymakers, both within the Administration and in Congress have a duty to ensure a stable Medicare system. This requires a baseline positive annual update reflecting inflation in practice costs, and the elimination, replacement, or revision of budget neutrality requirements to allow for appropriate changes in spending. The ongoing inadequacy of physician payment shines a spotlight on our flawed payment system.

To begin to address these many issues and reinforce the payment system for both physicians and their patients, the SVS, in collaboration with other organizations within the physician community, has urged Congress to consider several systemic reforms to the PFS. The Provider Reimbursement Stability Act of 2023 (Discussion Draft) reflects some initial thinking on several of these policy concepts, including:

1. **"Look back"/Reconciliation of Budget Neutrality Impacts**

CMS actuaries have on occasion grossly overestimated the impact of Relative Value Unit (RVU) changes in the fee schedule for new services/CPT codes, resulting in permanent removal of billions of dollars from the payment pool. This occurred in 2013 relating to the budget neutrality offset for Transitional Care Management (TCM), with a similar occurrence one year later during the adoption of Chronic Care Management (CCM) codes. In both instances, CMS' significant utilization overestimates

drove budget neutrality adjustments resulting in permanent reductions in MPFS payments. We are concerned that the disconnect between estimated and actual utilization will continue to result in similarly significant budget neutrality adjustments in the near future. For example, the current moratorium on implementation of the add-on code for "inherently complex" Evaluation and Management (E/M) services, which CMS initially estimated would be billed 100 percent of the time when applicable, will expire at the end of 2023. This assumption is highly speculative given CMS' past overestimates of TCM and CCM utilization and will trigger a harmful budget neutrality adjustment for 2024. While CMS has lowered the estimated utilization figures for this add-on code (G2211), the proposed rate will still trigger a budget neutrality adjustment which accounts for nearly 90% of this year's negative conversation factor adjustment of at least 3.4%.

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. As such, the SVS supports the establishment of a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for overestimates and return inappropriately reduced funding back to the payment pool.

2. **Raising the $20 million Budget Neutrality Trigger**

The $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the MPFS took effect. There have been no adjustments for inflation which means the PFS fails to reflect present-day dollars. Language needs to be added to the PFS statute to address this methodologic flaw.

3. **Timely updates for direct costs used to calculate practice expense RVUs;**

Establishing a cadence for timelier updates for both direct and indirect practice expense categories within the PFS will help mitigate the impact of future adjustments, such as the scenario resulting from the recent clinical labor update policy.

4. **Capping Variances within the PFS**

The SVS is generally supportive of concepts to provide stability within the PFS and establishing a mechanism to reduce significant variances associated with the conversion factor has merit. However, limiting these +/- variances has the potential for significant downstream impacts that must be analyzed before advancement of this policy. The SVS would appreciate the opportunity to engage with Committee members and staff to vet implementation options and evaluate the associated operational mechanics.

Other Legislative Concepts to Consider for Inclusion in the Provider Reimbursement Stability Act:

Services Exempt from Budget Neutrality Adjustments

Benefits or services for which utilization is expected to increase due to changes in law or regulations should be exempt from budget neutrality adjustments, including:

- Newly covered Medicare services (e.g., A&B scores from the United States Preventive Services Task Force related to preventive services, new types of facilities or health professional services added to the MPFS)
- Services that are being incentivized (e.g., physician bonuses, or no patient copay to encourage update of preventive services)
- Services specifically designed to be used within an APM that are already intended to lower Medicare expenditures
- Benefit or access expansions (e.g., telemedicine)
- New technology (i.e., things that could not be done before, like remote patient monitoring)

H.R. 2474, the Strengthening Medicare for Patients and Providers Act

H.R. 2474 amends current law to provide for an annual update to Medicare physician payment that is tied to inflation, as measured by the Medicare Economic Index (MEI). Providing an annual inflation update equal to the Medicare Economic Index (MEI) for Medicare physician payments is essential if physician practices are to be able to absorb payment distributions triggered by budget neutrality rules, performance adjustments, and periods of high inflation. It will also help physicians invest in their practices and implement new strategies to provide high-value care.

While there are many other concerns with the Medicare physician payment system that still need to be addressed, this legislation is an important first step toward fixing payment inequities and injecting more financial stability into physician practices, allowing them to invest in new ways of providing care and ultimately assuring Medicare beneficiaries have access to high-quality care. This legislation, spearheaded by Representatives Ruiz (D-CA) and Bucshon (R-IN)—both physician members of the Energy and Commerce Committee—would equate to a true foundational reform of the PFS.

Improving Seniors Timely Access to Care Act of 2023

Prior authorization, which is the practice by insurance companies of reviewing and potentially denying medical services and pharmaceuticals prior to treatment, remains a principal frustration for patients and physicians. This utilization management policy is overused, costly, opaque, burdensome to physicians, and harmful to patients due to delays in care.

Patients and providers continue to face unnecessary delays and denials of medically necessary care due to Medicare Advantage (MA) plans' prior authorization requirements. The Improving Seniors' Timely Access to Care Act would streamline and standardize prior authorization in the MA program by, among other things:

- Establishing an electronic prior authorization (ePA) program;

- Standardizing and streamlining the prior authorization process for routinely approved services, including establishing a list of services eligible for real-time prior authorization decisions;
- Ensuring prior authorization requests are reviewed by qualified medical personnel; and
- Increasing transparency around MA prior authorization requirements and their use.

In the 117th Congress, this bill garnered 326 bipartisan cosponsors and was reported favorably by both the Energy and Commerce and Ways and Means Committees before eventually being passed by the full House via a voice vote. Congress must prioritize passage of this sort of common-sense reform, and we appreciate the Committees leadership in ensuring its consideration in the 118th Congress.

The SVS thanks the Energy and Commerce Committee Leadership and Members for raising the profile of these important issues and looks forward to ongoing collaboration to identify and advance robust policy solutions designed to provide stability for both physicians and their patients. As has been noted, we remain deeply concerned with the inherent instability within the Medicare Physician Fee Schedule and the residual impact that year-over-year payment reductions have on physician practices and the patients they serve.

Absent systemic reform(s), the discrepancy between what it costs to run a physician practice and actual payment, combined with the administrative and financial burden of participating in Medicare, threatens the viability of many private and/or community-based practices, incentivizes market consolidation, and is driving physicians out of rural and underserved areas. None of these things are good for patient care.

Therefore, the SVS reiterates its commitment to work with all relevant stakeholders to identify and advance reforms that will ensure the Medicare physician payment system remains on a more sustainable and efficient path. We are continuing collaborative efforts across the House of Medicine to educate and build interest among Members of Congress regarding necessary reforms, and we look forward to additional engagement with the Committee to strengthen the Medicare physician payment system now, and for the future.

Sincerely,

Margaret C. Tracci, MD JD
Chair, SVS Advocacy Council

Joseph L. Mills, MD, DFSVS
President, Society for Vascular Surgery

U.S. House of Representatives
Energy & Commerce Committee
Subcommittee on Health

Hearing:
What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors

October 19, 2023

Statement for the Record
American Academy of Dermatology Association

Chairman Guthrie and Ranking Member Eshoo, 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, "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors."

The AADA supports the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474).

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

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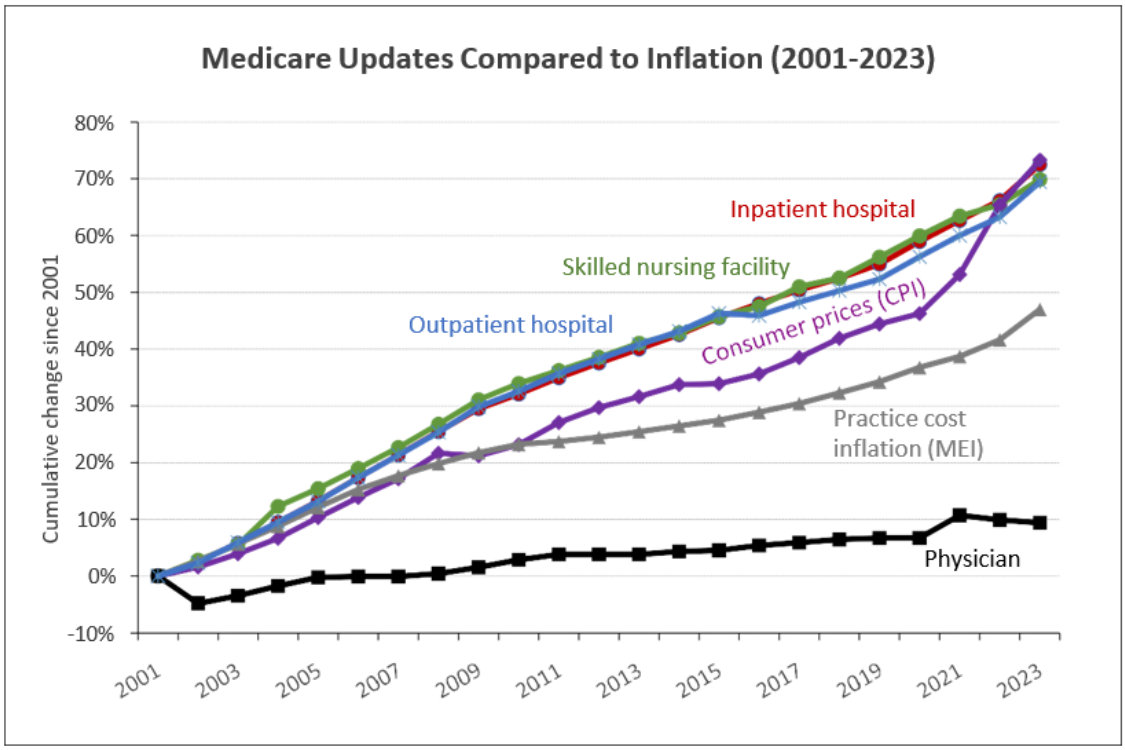
insurance that best meets their needs. The Medicare program must ensure beneficiaries have adequate access to networks of specialists and subspecialists, including board-certified dermatologists. This goal can only be possible when health care policy is driven by the welfare of patients over short-sighted 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, according to the calendar year (CY) 2024 MPFS proposed rule, physicians are expected to see a 3.4% payment cut on January 1, 2024.

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 26% from 2001 to 2023.* 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.



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]

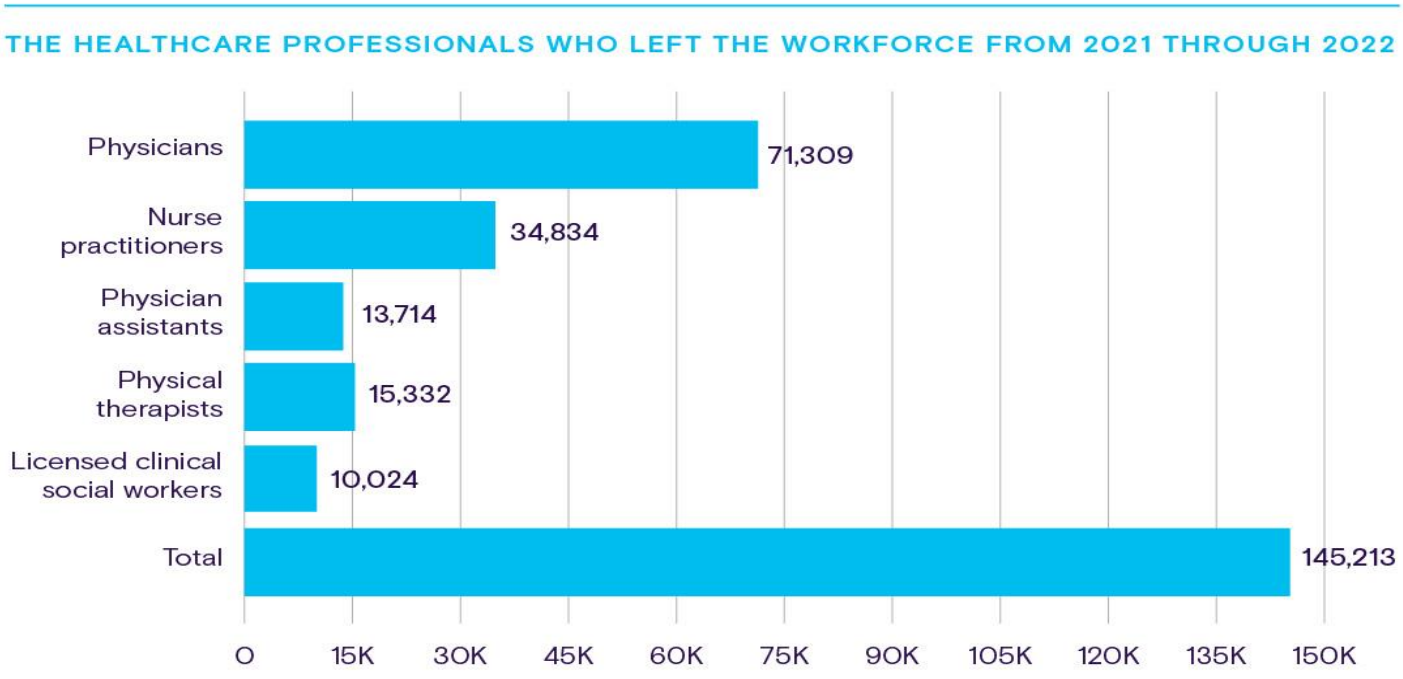


Fig. 1 Analysis of data from Definitive Healthcare's Atlas All-Payor Claims and PhysicianView products. Data sourced from a stable panel of billing organizations from Q1 2021 through Q1 2023. Physicians deemed as dropped out practiced in 2021 and ceased activity by Q4 of 2022. Some providers may still be practicing, but not filing claims. Data accessed September 2023.

[1] Addressing-the-healthcare-staffing-shortage-2023.pdf (definitivehc.com)

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 sub optimal 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. **The AADA urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide an inflationary update to the conversion factor under the Medicare physician fee schedule based on the Medicare economic index.**

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 three 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 consider several reform proposals that would improve patient access to care and provide financial stability for physicians. The AADA maintains that raising the budget neutrality threshold from $20 million, which has not been updated since 1992, would offer greater flexibility and would solve many of the underlying issues within the fee schedule that contribute to instability that jeopardizes patient access to care. Furthermore, the AADA supports a lookback period to reconcile both overestimates and underestimates of pricing adjustments for individual services, which will allow for the conversion factor to be calculated with more accuracy based on actual utilization data.

The AADA also supports exempting certain services from budget neutrality where utilization is expected to increase due to federal policy changes, including the newly covered services and technologies, high-value services that are incentivized or intended to lower Medicare expenditures, and service expansions.

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. The AADA remains skeptical that true health care value can be incentivized through payment penalties, and MIPS metric reporting has never been shown to sustainably improve system quality or value. If CMS is determined to move forward with specialty-specific MPV development, then we strongly recommend that this work proceed in close collaboration with specialty societies and be deployed as a pilot to prove value before wide dissemination. Any MVPs also must not add additional regulatory and administrative burden to already over-burdened practices.

The AADA strongly recommends that the only way to drive "more meaningful" participation from physicians is to allow the specialties to define and create their own value-based models. MVPs prescribed by CMS are a box checking exercise: a waste of valuable time that cuts into patient care and serves to demoralize physicians. They incur huge additional costs to practices, are not meaningful to the provider or the patient, and do not improve the quality of patient care.

Current drafts of MVPs (from CMS contracted agencies) have combined quality measures for a single disease with a cost measure for an unrelated disease. Knowing that value of care is mathematically defined by the combination of cost and quality of the same disease, we find these draft MVPs very concerning and incompatible with value-based care and the goals of where CMS would like to drive delivery. Additionally, the AADA is concerned that a dermatologic-focused MVP that includes a medley of measures will deter participation as the MVP will not be clinically relevant and further increase administrative burdens for providers. On the other hand, developing a single, narrow MVP will not be relevant to all physicians in a specialty.

To some degree, the move towards MVPs has the potential to address some of the pain points in traditional MIPS, but more broadly, the QPP needs to align with clinical relevance—especially for specialties like dermatology. The AADA recommends the following:

- Decrease the reporting requirement particularly for the quality category.
- Continue to offer exemptions for categories that are not relevant to an eligible clinician.
- Expand engagement in the promoting interoperability category from utilization of electronic health records (EHRs) to include use of other digital technologies that improve patient care.
- Offer different program tracks/requirements for small/solo practices versus large and/or multispecialty practices; and
- Provide greater incentive for successful program participation that are not tied to funds accumulated via penalties.

Furthermore, the QPP must keep a keen focus on preventing physician and staff burnout based on the Department of Health and Human Services' (HHS)[2] own priorities. This includes providing relief from systems-level factors that contribute to healthcare worker burnout by instituting measures that:

- Allow for removal of limitations from national and state regulation.
- 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.

Merit-based Incentive Payment System (MIPS)
The AADA recommends that Congress establish incentives, funding, and flexibility for physician offices with targeting toward small and solo practices.

Merit-based Incentive Payment System (MIPS) and Qualified Clinical Data Registries (QCDRs)
The AADA has made a significant investment in its QCDR, DataDerm, with a goal to drive improvement in the care of patients with skin disease. Large scale data collection, as facilitated by registries such as DataDerm, is key to enhancing our ability to measure clinical outcomes. Without the ability to consistently measure clinical outcomes, administration of value-based care systems is difficult to impossible. The AADA recognized the importance of registries in addressing this issue and we have spent almost a decade on the creation and growth of DataDerm. We have spent that time growing the registry and enhancing its capabilities. Reaching DataDerm's full potential has required that the AADA address a number of barriers.

EHR companies are private entities that concentrate on rights, ownership, competition, and revenue and pass additional costs on to the physician end users. In contrast, specialty societies such as the AADA have made substantial investments in registries and measure development with the goals of betterment of their respective specialty through science and data. **CMS has repeatedly put stringent requirements on QCDRs and specialty societies as requirements for participation in the MIPS program. However, CMS does not require that EHR companies work within that collaborative space.**

Scoring brings additional challenges. Feedback to clinicians and registries from CMS regarding post-submission scoring per member/practice and the penalty/incentives attached to that score is incomplete at best. This is detrimental to clinicians and specialty society registries. **Medical societies are drivers of information and standards within each respective specialty. Not closing the loop back to the societies, which are critical to implementation and improvement, impacts their ability to foster quality improvement efforts with clinicians.**

<u>Conclusion</u>
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

[2] Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce, 2022

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 Christine O'Connor, Associate Director of Congressional Policy at coconnor@aad.org.

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

Acknowledgement and Additional Author credits:
"Developing High Value Condition Based Bundled Episode Payment and Practice Models for Musculoskeletal Care: A Playbook"

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**The Consortium for the Next Generation of Alternative Payment Models is a multi-stakeholder coalition spear-headed by leaders from The University of Texas at Austin, Dell Medical School, Austin TX, Duke Margolis Center for Health Policy, Washington D.C; and Duke University Health System, Durham, NC.

Contents

A. Executive Summary

In response to the Center for Medicare and Medicaid Services 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 suboptimal 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 (e.g., 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 (e.g., 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. (e.g., 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 (e.g., 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 (e.g., surgery, physical therapy, anesthesia)
3. Capture but “bucket” lower value interventions (e.g., 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 (e.g., 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 (e.g., one member on March 13, another on April 3, 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 (readmissions, 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 (e.g., hyaluronic acid) and reduce intensity (e.g., steroid)	Financial
Advanced Imaging	Reduce utilization (e.g., MRI) and reduce intensity (e.g. 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 (e.g., $1000 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 (e.g., 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 mensc, 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, subs encntr
S83200D	Lower Extremity	Bucket-hndl tear of unsp mensc, current injury, r knee, subs
S83206A	Lower Extremity	Unsp tear of unsp meniscus, current injury, right knee, init
S83206D	Lower Extremity	Unsp tear of unsp meniscus, current injury, right knee, subs
S83207A	Lower Extremity	Unsp tear of unsp meniscus, current injury, left knee, init
S83207D	Lower Extremity	Unsp tear of unsp meniscus, current injury, left knee, subs
S83207S	Lower Extremity	Unsp tear of unsp meniscus, current injury, l knee, sequela

S83209A	Lower Extremity	Unsp tear of unsp meniscus, current injury, unsp knee, init
S83209D	Lower Extremity	Unsp tear of unsp meniscus, current injury, unsp knee, subs
S83221D	Lower Extremity	Prph tear of medial meniscus, current injury, r knee, subs
S83222D	Lower Extremity	Prph tear of medial meniscus, current injury, l knee, subs
S83231A	Lower Extremity	Complex tear of medial mensc, current injury, r knee, init
S83231D	Lower Extremity	Complex tear of medial mensc, current injury, r knee, subs
S83232D	Lower Extremity	Complex tear of medial mensc, current injury, l knee, subs
S83241D	Lower Extremity	Oth tear of medial meniscus, current injury, r knee, subs
S83242D	Lower Extremity	Oth tear of medial meniscus, current injury, left knee, subs
S83251A	Lower Extremity	Bucket-hndl tear of lat mensc, current injury, r knee, init
S83251D	Lower Extremity	Bucket-hndl tear of lat mensc, current injury, r knee, subs
S83261A	Lower Extremity	Prph tear of lat mensc, current injury, right knee, init
S83261D	Lower Extremity	Prph tear of lat mensc, current injury, right knee, subs
S83271A	Lower Extremity	Complex tear of lat mensc, current injury, right knee, init
S83281D	Lower Extremity	Oth tear of lat mensc, 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

20610	Arthrocentesis, Aspiration And/Or Injection; Major Joint Or Bursa (Eg, Shoulder, Hip, Knee Joint, Subacromial Bursa)
20611	Arthrocentesis, Aspiration And/Or Injection, Major Joint Or Bursa (Eg, Shoulder, Hip, Knee, Subacromial Bursa); With Ultrasound Guidance, With Permanent Recording And Reporting
20680	Removal Of Implant; Deep (Eg, 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 (Eg, 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 (Eg, Osteochondritis Dissecans Fragmentation, Chondral Fragmentation)
29875	Arthroscopy, Knee, Surgical; Synovectomy, Limited (Eg, Plica Or Shelf Resection) (Separate Procedure)
29876	Arthroscopy, Knee, Surgical; Synovectomy, Major, 2 Or More Compartments (Eg, 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 (Eg, Cardiac Fluoroscopy)
76000	Fluoroscopy (Separate Procedure), Up To 1 Hour Physician Or Other Qualified Health Care Professional Time, Other Than 71023 Or 71034 (Eg, 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 (Eg, 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
85652	Pathology & Labs
86140	Pathology & Labs
87641	Pathology & Labs
97163	Physical Therapy
G0502	Risk Modification
G0503	Risk Modification

20610	Arthrocentesis, Aspiration And/Or Injection; Major Joint Or Bursa (Eg, Shoulder, Hip, Knee Joint, Subacromial Bursa)
20611	Arthrocentesis, Aspiration And/Or Injection, Major Joint Or Bursa (Eg, Shoulder, Hip, Knee, Subacromial Bursa); With Ultrasound Guidance, With Permanent Recording And Reporting
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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
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73560,TC	Radiologic Examination, Knee; 1 Or 2 Views
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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 (Eg, Cardiac Fluoroscopy)
76000	Fluoroscopy (Separate Procedure), Up To 1 Hour Physician Or Other Qualified Health Care Professional Time, Other Than 71023 Or 71034 (Eg, 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 (Eg, 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
85652	Pathology & Labs
86140	Pathology & Labs
87641	Pathology & Labs
97163	Physical Therapy
G0502	Risk Modification
G0503	Risk Modification

American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

October 19, 2023

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to share the hospital field's comments on legislative proposals for consideration before the Energy and Commerce Committee Health Subcommittee on Oct. 19. We share the committee's commitment to providing the highest quality, best value health care for Medicare beneficiaries.

MEDICARE ADVANTAGE

H.R.___, the Improving Seniors' Timely Access to Care Act of 2023

The AHA supports the Improving Seniors' Timely Access to Care Act of 2023, which would help ensure access to care by streamlining prior authorization requirements under Medicare Advantage (MA) plans, including by making them simpler and more uniform and eliminating the wide variation in prior authorization requirements that frustrate both patients and providers. The legislation also requires MA plans to create a process of "real-time decisions" for services that are routinely approved, report on their use of prior authorization and the rate of approvals and denials and adopt policies that adhere to evidence-based guidelines.

While prior authorization, when used appropriately, can help align patients' care with their health plan's benefit structure, it is frequently applied inappropriately in ways that delay care and harm patients, as evidenced by a recent report by the Department of Health and Human Services Office of Inspector General that found 13% of MA plan prior authorization denials met Medicare coverage rules and should have been granted. In addition, a 2021 survey by the American Medical Association of more than 1,000 physicians underscores the negative impact on patient care resulting from prior authorization, finding that more than one-third (34%) of physicians reported that prior authorization led to a serious adverse event, such as hospitalization, disability or even death, for a patient in their care. Also, more than nine in 10 physicians (93%) reported care delays while waiting for health insurers to authorize necessary care, and more than four in five physicians (82%) said patients abandon treatment due to authorization struggles with health insurers. The statistics indicate that prior authorization policies are routinely not in the best interest of patients and can have detrimental effects on their care and clinical prognosis. These practices also add financial burden and strain on the health care system through inappropriate payment denials and increased staffing and technology costs to comply with MA plan requirements. They are also a major burden to the health care workforce and contribute to provider burnout. It is more important than ever to have greater oversight and accountability of MA plans, as provided for in this bill, to ensure their payments are being used for the intended purpose of paying for care.

PHYSICIAN-OWNED HOSPITALS

H.R.___, To amend title XVIII of the Social Security Act to revise certain physician self-referral exemptions relating to physician-owned hospitals

America's community hospitals and health systems welcome fair competition, where health care entities can compete based on quality, price, safety and patient satisfaction. But physician-owned hospitals (POH) — where physicians select the healthiest and best-insured patients and self-refer those patients to facilities in which they have an ownership interest — represent the antithesis of competition. **The AHA strongly opposes any changes that would either expand the number of POHs or ease**

restrictions on the growth of existing facilities. Allowing more POHs in rural areas could be particularly destabilizing because these areas already have a limited patient population, with hospitals struggling to maintain fixed-operating costs. Indeed, 150 rural hospital and health systems have closed since 2010, which has had a detrimental impact on their communities.

Congress acted in 2010 to close the "whole hospital" loophole in the Stark law and placed restrictions on POHs. That provision represented a carefully crafted compromise to protect hospitals with a Medicare provider number as of Dec. 31, 2010, and allow those facilities to expand when increased hospital capacity is needed.

Several analyses, including by the Congressional Budget Office, Medicare Payment Advisory Commission (MedPAC) and independent researchers, have concluded that physician self-referral leads to greater per capita utilization of services and higher costs for the Medicare program. In fact, according to the Congressional Budget Office, closing the "whole hospital" exception loophole in the Stark law reduced the federal deficit by $500 million over 10 years. Bills that would ease or repeal the 2010 law would help erase those savings and increase the federal deficit.

Furthermore, POHs tend to select the most profitable patients and services, jeopardizing communities' access to full-service hospital care. The Government Accountability Office, Centers for Medicare & Medicaid Services (CMS) and MedPAC found that patients in POHs tend to be healthier than patients with the same diagnoses who are cared for by community hospitals. This practice of self-referring physicians carefully selecting their patients creates a destabilizing environment that leaves sicker and less-affluent patients to community hospitals, thereby placing these hospitals at a distinct financial disadvantage. This is because community hospitals rely on cross-subsidies from those services targeted by POHs to support essential, but under-reimbursed, services such as emergency, trauma and burn care. In this way POHs threaten the ability of community hospitals to offer quality, comprehensive care and serve as the health care provider for all patients, regardless of income or insurance status, in their communities.

CLINICAL LABORATORY PAYMENTS

H.R. 2377, the Saving Access to Laboratory Services Act

Without Congressional action, hospital laboratories will face cuts as large as 15% on some of the most common tests, which will reduce access to clinical laboratory services and drive up the cost of care for patients and taxpayers. **The AHA supports the Saving Access to Laboratory Services Act (SALSA) (H.R. 2377), which would update Medicare's payment system for clinical diagnostic laboratory services and reduce data reporting burdens.** This bill would strengthen the clinical laboratory infrastructure and ensure that hospital labs are able to continue providing these critical services to patients.

H.R.___, To amend title XVIII of the Social Security Act to revise the phase-in of clinical laboratory test payment changes under the Medicare program

If Congress is unable to pass SALSA by the end of the year, we would support a bill to revise the phase-in of clinical laboratory test payment changes under the Medicare program. This would delay the harmful cuts to the Clinical Laboratory Fee Schedule as well as the next round of private payer rates reporting that are both scheduled to go into effect on Jan. 1, 2024, under the Protecting Access to Medicare Act.

QUALITY

H.R.___, the Fewer Burdens for Better Care Act of 2023

To improve the quality of care that patients receive, the AHA supports this bill to streamline reporting of the Medicare Quality Measures by calling for CMS to produce a list of measures it is considering removing from the program.

PHYSYCIAN PAYMENT

H.R. ___, To amend title XVIII of the Social Security Act to exempt certain practitioners from MIPS payment adjustments under the Medicare program based on participation in certain payment arrangements under Medicare Advantage

The bill would ensure MA alternative payment model (APM) participation is counted towards advanced APM calculations, and that those physicians participating in MA APMs at a high enough rate could be exempted from the Merit-based Incentive Payment System (MIPS). **The AHA supports this legislation.**

H.R.___, To amend title XVIII of the Social Security Act to allow for the use of alternative measures of performance under the Merit-based Incentive Payment System under the Medicare program

The legislation updates CMS’s "facility-based measurement" in the MIPS for clinicians who perform enough of their work in a hospital setting using quality and cost measures from CMS's hospital measurement programs, instead of asking them to report MIPS measures separately. This would enable more clinicians to take advantage of the facility-based scoring option and could assist with hospital–physician alignment in quality efforts. **The AHA supports this legislation.**

H.R.___, To amend title XVIII of the Social Security Act to extend incentive payments for participation in eligible alternative payment models

The AHA supports the provision of this legislation that extends the Advanced APM incentive payment at 3.5% for the calendar year 2026 period (though we would have preferred this amount restored to the 5% level). We are opposed, however, to the

provision of the bill that imposes a five-year cap on qualifying for payments; this will negatively impact those who are already enrolled in the Advanced APM models.

TELEHEALTH

H.R.___, the Telehealth Privacy Act of 2023

Current waivers are in place allowing practitioners to render telehealth services from their home, without having to report their home address on Medicare enrollment or claims forms. Beginning Jan. 1, 2024, these providers will be required to report their home address. **The AHA is deeply concerned with this requirement and recommend it be eliminated. It poses potential privacy issues to providers as home addresses may be publicly available without their knowledge or consent on sites like Medicare Care Compare.** Requiring providers to list their personal home addresses on enrollment and claims forms, to which patients or others in the public have access, poses privacy and safety risks given the increased incidence in violence against health care workers. Requiring providers to list their home address may disincentivize them from delivering telehealth services altogether (since they do not want their personal address listed publicly) and as such minimize telehealth's potential as a workforce retention tool for organizations. Hospitals and health systems also are concerned about the operational and administrative burden of completing enrollment forms for provider home addresses, as well as tracking and reporting changes in providers' home addresses if they move. **The AHA appreciates that this bill would ensure the privacy and safety of providers that deliver telehealth services from their homes by preventing providers' home addresses from being publicly available but encourage Congress to remove the requirement all together.**

CONCLUSION

Thank you for your consideration of the AHA's comments on these legislative proposals. We look forward to continuing to work with you to address these important topics on behalf of our patients and communities.

October 18, 2023

The Honorable Patrick McHenry
Speaker Pro Tempore
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Democratic Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

The Honorable Charles Schumer
Majority Leader
U.S. Senate
S-221, The Capitol
Washington, DC 20510

The Honorable Mitch McConnell
Republican Leader
U.S. Senate
S-230, The Capitol
Washington, DC

Re: Extend Medicare Advanced Alternative Payment Model Incentive Payments

Dear Speaker Pro Tempore McHenry, Leader Jeffries, Leader Schumer, and Leader McConnell:

On behalf of the 23 undersigned physician and health care associations and over 600 health systems, hospitals, physician practices, health clinics, and accountable care organizations (ACOs), thank you for your leadership in ensuring that physicians and other clinicians have adequate resources to care for the health of the U.S. population. As Congress considers priority end-of-year legislation, we ask that you bolster and advance the ongoing transition to value-based payment models by extending the 5 percent advanced alternative payment model (APM) incentive payments for clinicians that were authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Eight years ago, Congress passed MACRA to shift how Medicare pays clinicians for health care services. Key goals were to encourage keeping patients healthy, reducing unnecessary care, and lowering costs for both patients and taxpayers. APMs have demonstrated that when physicians and other clinicians are held accountable for costs and quality and provided flexibility from fee-for-service (FFS) constraints, they can generate savings for taxpayers and improve beneficiary care.

Recognizing that FFS payments alone are not sufficient to cover the expenses associated with building and maintaining the necessary infrastructure to engage in wholescale care delivery redesign, MACRA included 5 percent incentive payments to enable clinicians to transition to advanced APMs (i.e., down-side risk APMs). This strategy has proven successful as participation in advanced APMs has grown by more than 173 percent with nearly 300,000 clinicians.[1]

The advanced APM incentive payments have allowed clinicians to cover some of the investment costs of moving to new payment models, including expanding care teams, developing programs to improve beneficiary care, and adopting population health infrastructure. Incentives also help to improve care for patients by giving clinicians financial resources to expand services beyond those covered by traditional Medicare.

With the eligibility to earn advanced APM incentive payments set to expire at the end of 2023, progress towards value-based care could stall further. Absent Congressional intervention, physicians and other clinicians will be more likely to remain in MACRA's Merit-based Incentive Payment System (MIPS), which is burdensome, presents participants with financial costs associated with compliance and quality assurance measures, and does little to accurately assess improvements in health care outcomes. Moreover, some physicians currently in advanced APMs may be pushed back into MIPS because of increasing qualification thresholds, while others may choose to voluntarily shift back to MIPS because the program will continue to offer opportunities for high

[1] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2433/2021%20QPP%20Experience%20Report.pdf

performing APMs to qualify for MIPS adjustments in the coming years. The prospect of remaining in, or moving to, MIPS is particularly daunting as clinicians are slated for a 3.36 percent Medicare Part B payment cut stemming from the provisions in the Calendar Year 2024 Medicare Physician Fee Schedule Proposed Rule. Unless Congress intercedes, these payment reductions will take effect on January 1, 2024.

In recognition of our commitment to helping physicians and other clinicians move away from MIPS and advance Medicare's transition to accountable care, we urge you to include Section 3 of the Value in Health Care Act (H.R. 5013) in any end-of-year legislative package. This bipartisan legislation includes a two-year extension of MACRA's original 5 percent advanced APM incentives and adjusts the one-size-fits-all approach to revenue qualification thresholds to ensure that physicians and other clinicians continue to participate in APMs. These two crucial policy changes will help facilitate the continued transition to advanced APM arrangements while gradually increasing the associated revenue qualifications for incentive payments.

Lastly, Medicare's advanced APM incentives are a good return on investment. In 2022, ACOs produced $1.8 billion in savings that was returned to Medicare.[2] This savings is significantly more than the $644 million paid in incentives this year.[3] APMs may also be helping to slow the growth in health care spending in Medicare and beyond. The Congressional Budget Office (CBO) released data earlier this year showing that actual 2022 federal spending on Medicare and Medicaid was 9 percent lower than original projections.[4] Some of the features that characterize participation in APMs, such as improved care management and more efficient use of technology, are among factors that may have contributed to these lower-than-expected costs.

We ask you to advance this important legislation, which will give our organizations the flexibility and financial security needed to innovate care, improve the health of our populations, and lower health care costs.

We appreciate your consideration of this matter.

Sincerely,

American Medical Association
AMGA
National Association of ACOs
Accountable for Health
American Academy of Neurology
American College of Physicians
American Society for Radiation Oncology
America's Essential Hospitals
Association of American Medical Colleges
Federation of American Hospitals
National Rural Health Association
Primary Care Collaborative
America's Physician Groups
Health Care Transformation Task Force
Premier Inc.
American Academy of Family Physicians
American Association of Orthopaedic Surgeons
American Osteopathic Association
American Society of Nephrology
Association for Clinical Oncology
Association of Community Cancer Centers
Medical Group Management Association
Partnership to Empower Physician-Led Care

cc:
Chairwoman Cathy McMorris Rodgers
Chairman Jason Smith
Chairman Jodey Arrington
Chairman Ron Wyden
Chairman Sheldon Whitehouse
Ranking Member Frank Pallone
Ranking Member Richard Neal
Ranking Member Brendan Boyle
Ranking Member Mike Crapo
Ranking Member Charles Grassley

[2] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high
[3] https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2517/QPCount_IncentivePayments.pdf
[4] https://www.cbo.gov/system/files/2023-03/58997-Whitehouse.pdf

Health Systems, Hospitals, Physician Practices, Health Clinics, and ACOs

Accountable Care Coalition of Direct Contracting, LLC: AZ, CA, CO, CT, FL, GA, IL, MA, MI, NJ, NM, NY, OH, PA, TN, TX, UT, VA

Avera Health; Sioux Falls, SD, MN, IA, NE

Banner Health; Phoenix, AZ, CA, CO, NE, NV, WY

Bellin and Gundersen Health System; Madison, WI, MN, IA, MI

Bluestone Physician Services; Stillwater, MN, WI, FL

Caravan Collaborative ACO 22; AL,AR,AZ,CA,CT,FL,GA,HI,IA,ID,IL,IN,KY,LA,MI, MN,MO,MT,NC,ND,NE,NJ,NM,NY,OR,PA,SD,TX,WA,WI,WV,WY

Caravan Collaborative ACO 50; AR,CA,CO,GA,GU,IA,ID,IL,IN,KY,LA,MA,MI,MN,MO,MT,NC,ND,NE,OH,OR,TX,WA,WI,WV,WY

Care New England Medical Group; East Greenwich, RI, MA, CT

CareConnectMD ACO; CA, MI, SD, OH, IN, NY, TX, GA, FL, SC, NC, NE

Clover Health; NJ, FL, OK, NE, MO, IL, GA, KS, NM, TX

Collaborative Health Systems; AZ, CA, CO, CT, DC. FL, GA, IL, MA, MD, MI, NJ, NM, NY, OH, PA, TN, TX, UT, VA, WI

CommonSpirit Health; IL, AR, AZ, CA, CO, GA, IA, IN, KS, KY, MN, ND, NE, NM, NV, OH, OR, PA, TN, TX, UT, WA, WI

Community Care of Brooklyn; New York, NY

Essentia Health; Duluth, MN; WI; ND

Evolent Care Partners / The Accountable Care Organization, Ltd; CA, FL, IN, KS, KY, MI, NC, NY, TX, UT

HarmonyCares ACO; Troy, MI, OH, PA, VA, FL, TX, WA, MO, WI, IL, IN, GA

Health Choice Care; Miami, FL, HI, MO, NC, RI

ilumed, LLC; Jupiter, FL, SC, AL, WV, KY, OH, TX, NJ, NY, TN

Imperium Health; Louisville, KY, OK, AL, LA, FL, PA, CA, UT, NV, VA, AR, AK, TX, TN

Intermountain Health; UT; ID, NV, CO, MT

Jefferson Health, Philadelphia, PA & NJ

Lumeris; MO, OH, CA, GA

On Belay Health Solutions; MA; OR, CA, SD, NE, TX, FL, GA, TN, VA, IN, OH, PA, NJ, ME, RI

Prominence Health; CA; NV; TX; FL; DC; SC; OK

Providence; AK, WA, OR, CA, MT, TX, NM

Responsive Care Solutions; Sarasota, FL; MN, OH, AK, DE, TN, CO

Saint Alphonsus Health Alliance; Boise, ID & OR

Southeast Medical Group, PC, Atlanta, GA; AL & TN

Trinity Health Integrated Care, LLC; MI, IL, OH, PA, DE, IN, ID, FL, NY

Trinity Health Mid Atlantic; PA, DE

Trinity Health; MI ID, NY, PA, FL, DE, IL, OH, IA, CT, MA

Upstream; NC, VA, SC

USMM Accountable Care Partners; MI, OH, PA, VA, FL, GA, TX, MO, WA, WI, IL, IN

Valley Health System; VA; WV

Vanderbilt Health Affiliated Network; TN, KY

VillageMD; OR, NV, AZ, CO, TX, IL, IN, MI, KY, GA, FL, NJ, RI, MA, NH

Votion ACO; FL, GA, AL, TX, SC, MI, OK, TN, MS

Wellvana; TN VA, WI, MI, GA, FL, CA, TX, LA, NY, SC, NC, AR, MO, OH, OK, KS, AZ, NM

Aaron M. Roland, M.D.; Burlingame, CA

Abimbola M. Banjo M.D. P.A.; Pleasanton, TX

Access Family Medicine of Sacramento; Sacramento, CA

Accountable Care Coalition of Georgia, LLC.

Accountable Care Coalition of Northeast Partners, LLC

Accountable Care Coalition of Southeast Texas, Inc.

Accountable Care Coalition of Southeast Wisconsin, LLC

Advance Family Practice, LLC; Florida

AdvantagePoint Health Alliance, LLC

AdvantagePoint Health Alliance, LLC - Blue Ridge

AdvantagePoint Health Alliance, LLC - Bluegrass

AdvantagePoint Health Alliance, LLC - Hot Springs

AdvantagePoint Health Alliance, LLC - Laurel Highlands

AdvantagePoint Health Alliance, LLC - Northwest

AdvantagePoint Health Alliance, LLC - Tennessee Valley

AdvantagePoint Health Alliance, LLC - Western North Carolina

AdventHealth; Orlando, FL

Adventist Health, Roseville, CA

Advocate Health; Oak Lawn, IL, WI, GA, NC, SC

agilon health, Texas

Aledade Accountable Care 101, LLC

Aledade Accountable Care 102, LLC

Aledade Accountable Care 103, LLC

Aledade Accountable Care 12, LLC

Aledade Accountable Care 128, LLC

Aledade Accountable Care 143, LLC

Aledade Accountable Care 147, LLC

Aledade Accountable Care 149, LLC

Aledade Accountable Care 15, LLC

Aledade Accountable Care 16, LLC

Aledade Accountable Care 22, LLC

Aledade Accountable Care 25, LLC

Aledade Accountable Care 34, LLC

Aledade Accountable Care 35, LLC

Aledade Accountable Care 37, LLC

Aledade Accountable Care 38, LLC

Aledade Accountable Care 45, LLC

Aledade Accountable Care 48, LLC

Aledade Accountable Care 57, LLC

Aledade Accountable Care 58, LLC

Aledade Accountable Care 59, LLC

Aledade Accountable Care 60, LLC

Aledade Accountable Care 61, LLC

Aledade Accountable Care 79, LLC

Aledade Accountable Care 80, LLC

Aledade Accountable Care 90, LLC

Aledade Accountable Care 91, LLC

Aledade Accountable Care 92, LLC

Aledade Accountable Care 93, LLC

Aledade Accountable Care 94, LLC

Aledade Accountable Care 98, LLC

Aledade Accountable Care 99, LLC

Aledade Arkansas ACO, LLC

Aledade Delaware ACO LLC
Aledade Duwamish ACO, LLC
Aledade Florida Central ACO, LLC
Aledade Kansas ACO, LLC
Aledade Louisiana ACO, LLC
Aledade Mississippi ACO, LLC
Aledade Primary Care ACO LLC
Aledade West Virginia ACO, LLC
Aledade, Bethesda, MD
Aledo Family Medicine; Aledo, TX
Alicia W Grossmann M.D. Pa; Austin, TX
Alignment Health; Orange, CA
Alleghany Health; Sparta, NC
Allen Parish Community Healthcare; Kinder, LA
Altamonte Family Practice; Florida
Amin Medical Center; Skippack, PA
AMITA Health ACO, Chicago, IL
AmpliPHY of Kentucky ACO LLC
Andre K.S. Tse, M.D. PA; Jacksonville, NC
AnMed; Anderson, SC
Ann Arbor Endocrinology; Ann Arbor, MI
Ann H. Snyder, M.D., PA; McKinney, TX
Anna Abalos, M.D.; Roseville, CA
Antone Internal Medicine and Associates; Southfield, MI
Apex Primary Care; Florida
Apple Hill Podiatry Associates PC; Pennsylvania
Aquino Integrative Internal Medicine; Roseville, MI
Arbor Ypsi Foot & Ankle Center; Ann Arbor, MI
Arcadia Solutions, LLC; Burlington, MA
Arcare, Augusta, AR
Archbold Medical Center; Thomasville, GA
Arkansas Health Network; Little Rock, AR
Arthur Powell, M.D.; Bingham Farms, MI
Ascension Saint Thomas; Nashville, TN
Ascension; St. Louis, MO
Associated Endocrinologists; Farmington Hills, MI
Associated Family Physicians, Inc.; Sacramento, CA
Associates in Internal Medicine; West Bloomfield, MI
Associates in Physical Medicine & Rehab; Ypsilanti, MI
Assurity DCE, LLC; Trinity, FL
Atlantic Accountable Care Organization; Morristown, NJ
AtlantiCare; Atlantic City, NJ
Auburn Hills Medical Clinic; Auburn Hills, MI
Auburn Medical Group, Inc.; Auburn, CA
Azelvandre Family Practice; Florida
Baptist Health Quality Network; Coral Gables, FL
Baptist Health South Florida; Miami, FL

Barrett Hospital & Healthcare; Dillon, MT
Bay Family Medical Group; San Mateo, CA
Baycare Healthcare Partners; Springfield, MA
Be Well Medical Center; Berkley, MI
Beartooth Billings Clinic; Red Lodge, MT
Beaumont ACO; Southfield, MI
Bellin Health Partners; Wisconsin, MI
Bensalem Medical Practice, PC; Bensalem, PA
Beth Hanrahan, MD LLC; Florida
Better Health Group; Tampa FL
Bibb Medical Center; Centerville, AL
Billings Clinic; Billings MT
BJC Accountable Care Organization; St. Louis MO
Block, Nation, Chase & Smolen Family Medicine; Florida
Bloom Healthcare; Wheat Ridge, CO
Bluerock Care; Washington, DC
Bluestem Health; Lincoln, NE
BoiceWillis Clinic, P.A.; Rocky Mount, NC
Bond Clinic, P.A.; Winter Haven, FL
Bradon Kimura MD Inc; Kealakekua; HI
Bridges Health Partners, LLC; Warrendale, PA
Bucks Family Medical Associates P.C.; Newtown, PA
BuxMont Medical Associates, PC; Warrington, PA
Cancer Care Associates of York Inc; Pennsylvania
Capital Family Medicine; Raleigh, NC
Capital Family Physicians, P.A.; Raleigh, NC
Capitol Internal Medicine Associates; Carmichael, CA
Caravan Rural Health ACO, Colorado
Cardiology and Vascular Associates, P.C; Bloomfield Hills, MI
CareConnectMD, Inc.; Costa Mesa, CA
Carilion Clinic; Roanoke, VA
Carle Health; Champaign, IL
Carrboro Family Medicine Center, PA; Carrboro, NC
Cary Healthcare Associates, P.A.; Cary, NC
Cary Internal Medicine and The Diabetes Center; Cary, NC
Cary Medical Group; Cary, NC
Casillas Medical and Wellness; Florida
Central Bucks Family Practice; Jamison, PA
Central Florida ACO, LLC; New Port Richey, FL
Central Montana Medical Center; Lewistown, MT
Central Virginia Coalition of Healthcare Providers, LLC dba JerichoREACH ACO
Centrus Health Kansas City; Westwood, KS
Centry Valley Community Partners LLC; Modesto, CA
Chambersburg Health Services; Pennsylvania
Charles E Schalger, MD LTD d/b/a Family Health Associates; Pennsylvania
CHESS Health Solutions; Winston-Salem, NC
Cheyenne Regional; Cheyenne, WY

CHI Health Partners; Omaha, NE

Christiana Care Quality Partners ACO, LLC d/b/a eBrightHealth ACO; Wilmington, DE

Christie Clinic, PLLC; Champaign, IL

Christine Meyer, MD And Ass; Exton, PA

Christopher Greater Area Rural Health Planning Corporation; West Christopher, IL

Christus Health; Texarkana, TX

City Healthcare; Florida

Civitas Networks for Health; National

Clark Fork Valley Hospital; Plains, MT

Clarkston Internal Medicine; Clarkston, MI

Clarkston Medical Group; Clarkston, MI

Clarkston Medical Group; Oxford, MI

Clermont Medical Center; Florida

Cleveland Clinic; Cleveland, OH, FL, NV

Clover Fork Outpatient Medical Project; Evarts, KY

CNY Family Care, LLP; East Syracuse, NY

CNYAIM / IHANY; Syracuse, NY

Coal Country Community Health Center; Center, ND

Coastal Carolina Quality Care, Inc.; New Bern, NC

Commonwealth Primary Care ACO LLC; Phoenix, AZ

Commonwealth Primary Care; Richmond, VA

Community Care Collaborative; Huntingdon Valley, PA

Community Health Center of Lubbock, Inc.; Lubbock, TX

Community Health Provider Alliance, Denver, CO

Community Healthcare Partners ACO; Munster, IN

Community Memorial Healthcare; Ventura, CA

Community Memorial Hospital; Hamilton, NY

Complete Care Family Medicine Associates; Florida

Cone Health, Greensboro, NC

ConnectAmerica; Bala Cynwyd, PA

Conrad and Lieberman, MDs; Chester, PA

Coordinated Healthcare Services, P.A.; Plano, TX

Core Physicians, LLC / NH Cares ACO; Exeter, NH

Coulee Medical Center; Grand Coulee, WA

Cumberland Center for Healthcare Innovation, LLC (CCHI); Cookeville, TN

Dallastown Medical Associates LLP; Pennsylvania

Dana Kerner LLC; Southampton, PA

David Bene, MD; Pennsylvania

David Fivenson, MD, Dermatology, PLLC; Ann Arbor, MI

David Paul Adams, M.D., P.A.; Cary, NC

Dawei Zheng, M.D.; Sacramento, CA

Deaconess Care Integration LLC; Evansville, IN

Delaware Valley ACO; Radnor, PA

Delikat Family Practice; Florida

Dennis S. Gray, M.D.; Louisville, KY

Devamani Gowda, M.D.; Roseville, CA

Dewitt Clinic, Alvin, TX

DHR Health; Edinburg, TX
Dina Sverdlov, M.D.; San Mateo, CA
Doctors ACO, LLC; Athens, GA
Doctors Emergency Service, PA; Annapolis, MD
Dominion Medical Associates, P.A.; Austin, TX
Douglas Young, M.D., Inc; Sacramento, CA
Dover Shores Family Practice, LLC; Florida
Doylestown Medical Associates, P.C.; Doylestown, PA
Doylestown Value Partners; Doylestown, PA
Drs. Borders and Associates; Lexington, KY
Drs. Elias & Oakley, MD PA; Florida
Duke Connected Care; Durham, NC
Duly Health and Care; Wheaton, IL
Eastpointe Family Physicians; Eastpoint, MI
Elkins Park Family Medicine; Elkins Park, PA
Equality Health Direct; Phoenix, AZ
Esse Health ACO; St. Louis, MO
Evolent Care Partners; Raleigh, NC
Family First Health Corporation; Pennsylvania
Family First Primary Care, PLLC; Wake Forest, NC
Family Health Care Center; Royal Oak, MI
Family Health West; Fruita, CO
Family Medical Center of Georgetown, P.A.; Georgetown, TX
Family Medical Center; Florida
Family Medical Center; Orlando, Florida
Family Medical Specialist of Florida, PLC; Florida
Family Medicine & Ambulatory Care Center; Fair Oaks, CA
Family Medicine Clinic, PC
Family Medicine Clinic; Pearsall, TX
Family Practice; Warren, MI
Feasterville Family Practice, LLP; Holland, PA
First Care Health Center; Park River, ND
Florida Accountable Care Services; Winter Park, FL
Folsom Lake Primary Care; Folsom, CA
Fort HealthCare, Inc; Fort Atkinson, WI
Franciscan Missionaries of our Lady Health System; Baton Rouge, LA
Fred Tehrani MD LLC; Philadelphia, PA
Freedom Healthcare Alliance; Charleston, SC
Gammons Medical; Warren, MI
Geisinger Medical Group; Danville, PA
Geisinger; Wilkes Barre, PA
Generations Family Practice, P.A.; Cary, NC
Genesis Health System; Davenport, IA, IL
Gettysburg Family Practice Inc; Pennsylvania
Gill Medical and Geriatrics Associates; Scottsburg, IN
Glatt Medical Limited Partnership; Burlingame, CA
Glendive Medical Center, Inc.; Glendive, MT

Grand View Health; Sellersville, PA
Granger Medical Clinic, PC; Salt Lake City, UT
Greater Louisville Internal Medicine; Louisville, KY
Greater Louisville Internal Medicine; Prospect, KY
Green and Seidner Family Practice Associates; Landsdale, PA
Greenhaven Family Practice; Sacramento, CA
Greentree Primary Care; Clarksville, IN
GS Peter Gross DO PC; Philadelphia, PA
Guam Seventh-day Adventist Clinic; Tamuning, Guam
Hancock Health; Greenfield, IN
Hanover Family Practices Associates LLC; Pennsylvania
Hazel Park Medical Center; Hazel Park, MI
Health Choice
Health Choice Community Partners
Health Partners for the Elderly; Parkway Lutz, FL
Healthcare Partners of the North Country ACO, Watertown, NY
HealthChoice LLC; Memphis, TN
Heart of Texas Community Health Center, Inc dba Waco Family Medicine, Waco, TX
Hematology Oncology Consultants; Troy, MI
Hendricks Regional Health, Danville, IN
Henry Ford Physicians Accountable Care Organization dba Mosaic ACO; Detroit, MI
Holy Redeemer Family Medicine; Bensalem, PA
Hospital Physicians Network; Farmington Hills, MI
Houston Methodist Coordinated Care; Houston, TX
Howard County Medical Center; St. Paul, NE
IHC Quality Partners; Canton, OH
Imperial Center Family Medicine and Immediate Care; Durham, NC
Independent Physicians of Wisconsin/Medpoint; Milwaukee, WI
Indian Valley Family Practice; Souderton, PA
Indiana Lakes Accountable Care Organization; Goshen, IN
Innovation Care Partners; Scottsdale, AZ
Innovative Healthcare Collaborative of Indiana; Evansville, IN
Inspira Health; South New Jersey
Integra Community Care Network; Providence, RI
Internal Medicine & Cardiology Associates; Florida
Internal Medicine MD, LLC; Florida
Internal Medicine Pediatrics Associates, P.A; Cary, NC
Internal Medicine Physicians; Farmington Hills, MI
Internal Medicine Primary Care Physicians; Bloomfield Hills, MI
Internal Medicine Specialists; West Bloomfield, MI
inVio Health Network, Greenville, SC
Iowa Primary Care Association; Des Moines, IA
Jacksonville Children's and Multispecialty Clinic, PA; Jacksonville, NC
Jacobs And Van Cleeff Internal Medicine, PC; Cary, NC
Jericho Reach, Central VA
John C. Chow, M.D.; San Mateo, CA
John R Medical Center; Madison Heights, MI

John T. Littell M.D. PA; Florida

Johnson Memorial Health, Franklin, IN

Jose I Sosa, M.D.; Pearsall, TX

Joseph A Marotta, M.D. PA; San Antonio, TX

Juan P. Suarez, MD; Florida

Kemper And Kemper, MDs; Louisville, KY

Kenan & Wang, LLC; Sacramento, CA

Kendall Wong, M.D.; Odessa, TX

Kernersville Primary Care; Kernersville, NC

Kevin Stephens M.D. PA; Austin, TX

Keystone Accountable Care Organization; Danville, PA

Keystone Rural Health Center; Pennsylvania

Kim kuhar DO internal medicine, PC; Silverdale, PA

Kingswood Internal Medicine; Bloomfield Hills, MI

Kolender Medical; Bingham Farms, MI

Krzysztof W. Warszawski, M.D.; Garden City, MI

Kurtis Fox, M.D.; Colfax, CA

Lagrange Family Care Doctors; La Grange, KY

Lake Howell Health Center (Hoffman); Florida

Lakes Internal Medicine; West Bloomfield, MI

Lakowsky and Batlin Medical Corp.; Burlingame, CA

Lancaster General Health Community Care Collaborative, Lancaster, PA

Langdon Prairie Health, Langdon, ND

Langdon Prairie Health; Langdon, ND

Lebanon Internal Medicine Associates, P.C.; Pennsylvania

Lebanon Valley Family Medicine Inc; Pennsylvania

Lee Health; Fort Meyers, FL

Legacy Community Health Services, Inc.; Houston, TX

Legends Medical Clinic PLLC; Round Rock, TX

Leo Toupin, M.D. PA; Austin, TX

Lewerenz Medical Center & Longevity Health Institute; Rochester Hills, MI

LHS Health Network; Camden, NJ

Lifepoint Health; Brentwood, TN

Lifetime Family Care; Madison Heights, MI

Lily Enayati, M.D.; San Mateo, CA

Lincoln Medical Associates; Lincoln, CA

LMG Family Practice; Landsdale PA

Logan Health; Flathead County, MT

Lost Rivers Medical Center; Arco, ID

Loyola Physician Partners; Maywood, IL

LTC ACO; Pennsylvania

Luminis Health, Annapolis, MD

Lycoming Internal Medicine, Jersey Shore, PA

Main Line Health; Bryn Mawr, PA

MaineHealth, Portland, ME

Maria's Healthcare Service; Shelby, MT

Marshall Health Network; Huntington, WV

Martin Podiatry PC; Pennsylvania

Mass General Brigham; Boston, MA

McAuley Health Partners ACO, LLC; Ann Arbor, MI

McDermott-Sitzman Association; Washington, DC

McDonough District Hospital; McDonough County, IL

McKenzie Health System; Sandusky, MI

McKenzie Health; Watford City, ND

MD Valuecare, LLC; Richmond, VA

Medical Associates of NWA, P.A.; Fayetteville, AR

Medical Associates of Southern KY; Glasgow, KY

Medical Office of Tara L Cuda, DO, Philadelphia, PA

Memorial Community Health Inc.; Aurora, NE

Memorial Community Hospital and Health System; Blair, NE

MercyOne Population Health Services Organization, Iowa

MercyOne, Des Moines, Iowa

Meritas Health, Kansas City, MO

Methodist Alliance for Patients and Physicians, Dallas, TX

Methodist Patient Centered ACO; Dallas, TX

Methodist Physicians Clinic; Omaha, NE

MHP Palliative Care; Farmington Hills, MI

Michael Fox, D.O., DABAM; Livonia, MI

Michigan Premier Internists; Southfield, MI

Mid-Atlantic Collaborative Care, LLC

Middletown Medical; Middletown, NY

Millennium Affiliated Physicians; Farmington Hills, MI

Millennium Physician Group; Florida

Mission Health Partners; Asheville, NC

Mobile Physician Associates; Los Angeles, CA

Mohammad N. Alocozy, M.D; Sacramento, CA

Mon Health System; Morgantown, WV

Monticello Medical Associates - Monticello, KY

Monument Health; South Dakota

Morris Hospital and Healthcare Centers; Morris, IL

Mount Carmel Health Partners; Columbus, OH

Mount Sinai Health System; New York, NY

Mount Sinai Morningside, Mount Sinai Health System, New York, NY

Mountain View Hospital; Idaho Falls, ID

MultiCare Connected Care; Tacoma, WA

MUSC Health Alliance; Charleston, SC

Myrtue Medical Center; Harlan, IA

Nathan J, Hershberger, PLLC; Florida

Nebraska Health Network; Omaha, NE

Nebraska Medicine; Omaha, NE

Neil A. Patterson, M.D., P.A.; Florida

New Britain Family Practice, New Britain, PA

New Era Healthcare Henrico, VA

New Liberty Hospital Corporation; Liberty, MO

New Providence Internal Medicine Associates/Primary Care Partners; Providence, NJ

Next ACO, LLC; Trinity, FL

NOMS Healthcare, LLC; Sandusky, OH

NorCal Endocrinology & Internal Medicine; Roseville, CA

Nor-Lea Hospital District; Lovington, NM

North Austin Family Medicine, PA; Austin, TX

North Carolina Internal Medicine, PC; Cary, NC

North Raleigh Medical Center; Raleigh, NC

North Star Family Medicine P.A.; Round Rock, TX

Northern Light Health; Brewer, ME

Northern Medical Group; Poughkeepsie, NY

Northfield Hospital + Clinics; Northfield, MN

NW Momentum Health Partners ACO; Olympia, WA

Oakland Family Practice; Madison Heights, MI

Ochsner Health; New Orleans, LA; MS; TX

Odessa Consultants, PLLC; Odessa, TX

Odessa Memorial Healthcare Center; Odessa, WA

Office of Dr. Meyers; Bloomfield Hills, MI

Office of Imad George M.D.; Livonia, MI

Office of Langnas and Stashefsky; Madison Heights, MI

Office of Mary Ferris M.D.; Warren, MI

Ogden Clinic, PC; Ogden, UT

Olmsted Medical Center; Rochester, MN

On Point Medical Group; Denver, CO

OneCare Vermont ACO; Colchester, VT

OneHealth Nebraska; Lincoln, NE

Optimus Healthcare Partners ACO; Summit, NJ

Optum; Eden Prairie, MN

Orlando Health; Florida

Orlando Primary Care, PA LLC; Florida

Osceola Women & Family Medicine Specialists; Florida

Pankaj J Patel, M.D., P.A; Midland, TX

Parkside Family Medicine; Philadelphia, PA

Patient Quality Alliance; Pocatello, ID

Paul E. Bristol, M.D.; Austin, TX

Paul M. Izes, D.O.; Southampton, PA

Paul R. Ehrmann, D.O.; Troy, MI

Pentahealth Primary Care; Downingtown, PA

Pentahealth; West Chester, PA

Peter R. Honig, D.O.P.C.; Philadelphia, PA

Physician Organization of Michigan ACO; Ann Arbor, MI

Physician Performance LLC; Woburn, MA

Physicians Primary Care of SW FL; Fort Myers, FL

Piedmont Adult and Pediatric Medicine Associates; Gastonia, NC

Pinellas County Primary Care & Hospitalists, PLLC; Florida

Pinnacle Physicians Group; Feasterville-Trevose, PA

Port Lavaca Clinic Associates, P.A.; Port Lavaca, TX

Pottstown Medical Specialists, Inc.; Pottstown, PA
Preferred Medical Group; Madison Heights, MI
Premier Ankle & Foot Specialists PC; Pennsylvania
Premier Internists; Farmington Hills, MI
Primary Care Centers of Eastern Kentucky; Hazard, KY
Primary Care Development Corporation; New York, NY
Primary Care Specialists of Orlando - Orange Avenue; Florida
Primary Partners ACO; Florida
Primary Partners Alliance; Clermont, FL
Primary Partners; Clermont, FL
Privia Health; Arlington,VA
Privia Medical Group, North Texas
Progressive Health Care, P.C.; Taylor, MI
Prospect Medical Holdings; Los Angeles, CA
PSW, Washington State
Pullman Regional Hospital; Pullman, WA
Purisima Family Medicine; Half Moon Bay, CA
Rajanikant Pandya, M.D; Midland, TX
Rajesh J Patel, M.D., P.A.; Odessa, TX
Raleigh Adult Medicine; Raleigh, NC
Raleigh Family Practice, P.A; Raleigh, NC
Raleigh Medical Group; Raleigh, NC
Rancho Health Management; Riverside, CA
Redford Clinic; Redford, MI
Reed Relations Consulting, LLC; Catawissa, PA
Reid Health; Eastern IN & Western, OH
Revere Health, Provo, UT
Richmond Quality ACO; Staten Island, NY
Rittenhouse Internal Medicine, Philadelphia, PA
Ritu Suri MD LLC; Englewood NJ
Riverwood Healthcare Center; Atikin, MN
RMG Gastroenterology; Raleigh, NC
Rochester Medical Group; Rochester Hills, MI
Rocklin Family Practice & Sports Medicine; Rocklin, CA
Rocky Mount Family Medical Center, P.A.; Rocky Mount, NC
RSI Medical; Wendell, NC
Rush Health, Chicago, IL
Ryan Medical Associates, P.C.; Warren, MI
Saint Francis Health System, Tulsa, OK
Samaritan Healthcare; Moses Lake, WA
Sammy Lerma III, M.D., PA; Bastrop, TX
Sanjay Pethkar MDSC; Plainfield, IL
Sayed A. Hussain, M.D.; Roseville, CA
Schaefferstown Family Practice Inc.; Pennsylvania
Scottsdale Imaging Services, LLC; Scottsdale, AZ
Scripps Accountable Care Organization, LLC; San Diego, CA
SDI Services, LLC; Arizona

Select Health Network; Mishawaka, IN
Sellersburg Internal Medicine & Pediatrics; Sellersburg, IN
Sergio B Seoane M.D.; Florida
Shah And Associates Family Practice; Cary, NC
Shenandoah Medical Center; Shenandoah, IA
Shroff Cardiology & Internal Medicine Clinic Pa; Big Spring, TX
Shylesh Ganta, M.D., P.A; Midland, TX
Sidney Health Center; Sidney, MT
Silver Pine Medical Group; Sterling Heights, MI
Silver State ACO; Las Vegas, NV
SMP Health - St. Kateri; Rolla, ND
SOMOS ACO; New York, NY
SoNE Health; Windsor, CT
South Macomb Internists; Warren, MI
South Texas Internal Medicine Associates; San Antonio, TX
Southeast Health Statera Network; Dothan, AL
Southeastern Health Partners; Greenville, SC
Southern Atlantic Healthcare Alliance; Cary NC
Southwest Diagnostic Imaging, LLC; Scottsdale, AZ
Southwest Healthcare Services; Bowman, ND
Southwest Internal Medicine Specialists; Florida
Southwest Medical Imaging, Ltd; Scottsdale, AZ
Space Coast ACO, LLC; New Port Richey, FL
Stephen J. Carney, M.D.; Burlingame, CA
Stephen J. Shields, MD PA; Florida
Stephen Williams Internal Medicine MD PC; Troy; MI
Sterling Physicians; Sterling Heights, MI
Stratum Med; Champaign, IL
Subodh K Mallik, M.D.; Ft. Stockton, TX
Summit Health; Berkeley Heights, NJ
Summit Healthcare Regional Medical Center; Show Low, AZ
Summit Physician Services; Pennsylvania
Suncoast Premier Medical, LLC; Florida
Sunflower Medical Group P.A.; Kansas City, KS
Suresh Prasad, M.D. PA; Odessa, TX
Sutter Health; Sacramento, CA
Tandigm Health; West Conshohocken, PA
Tandigm Value Partners; Southeastern, PA
TC2; Macon, GA
TeamHealth; Knoxville, TN
The Center for Health Affairs; Cleveland, OH
The Doctor's In, Inc.; Roseville, CA
The Iowa Clinic, Des Moines, IA
The South Bend Clinic; South Bend, IN
The Wright Center for Community Health and Graduate Medical Education; Scranton, PA
Think Whole Pearson Healthcare; Omaha, NE
Thomas Hopkins, M.D.; Roseville, CA

Thundermist Health Center, Warwick, RI
Tommy T. Kuo, M.D.;San Mateo, CA
Torrance Memorial Integrated Physicians, LLC; Torrance, CA
Total Family Healthcare; Florida
Traci Thompson, MD PA; Florida
Triad HealthCare Network; Greensboro, NC
Triad Internal Medicine; Asheboro, NC
Triad Primary Care, PLLC; Greensboro, NC
Trinsic; Denver, CO
TriState Health; Clarkston, WA
Tryon ACO, LLC; Charlotte, NC
Twin Lakes Family Medicine; Bloomfield Hills, MI
UC San Diego Health; San Diego, CA
UMass Memorial Health; Worcester, MA
UNC Senior Alliance/UNC Health; Chapel Hill, NC
United Hospital District; Blue Earth MN
UnityPoint Accountable Care; Des Moines, IA
University Internal Medicine, Inc; Pawtucket, RI
Vanderbilt University Medical Center; Nashville, TN
Versailles Family Medicine; Versailles, KY
Vikram Vadyala, M.D.; Midland, TX
Virginia Care Partners; Richmond, VA
Vista Complete Care; Auburn, CA
Vital Medicine PC; Livonia, MI
Vraj Medical LLC; Florida
Vytalize Health; Hoboken, NJ
Wake Internal Medicine & Pediatrics; Raleigh, NC
Wake Internal Medicine Consultants, Inc.; Raleigh, NC
Wakely, an HMA Company (Nationwide)
WellSpan ACO; York, PA
WellSpan Medical Group; Pennsylvania
Wellvana Health; Nashville, TN
Wesley R. Barnes, M.D.; Royal Oak, MI
West Florida ACO, LLC; Tampa Bay, FL
Western Wake Wellness; Cary, NC
Westland Clinic; Westland, MI
Westland Healthcare; Westland, MI
WinnMed; Decorah, IA
Winona Health; Winona, MN
Winter Garden Health and Wellness; Florida
Winter Park Family Practice; Florida
Wrightstown Family Medicine; Newtown, PA
Xin-Nong Li M.D., Inc.; Fair Oaks, CA
Yorktowne Urology PC; Pennsylvania
You and Your Health Family Care; Florida
Zia ACO, LLC; Taos, NM