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WHAT IS THE PROGNOSIS? EXAMINING MEDICARE PROPOSALS TO IMPROVE PATIENT ACCESS TO CARE AND MINIMIZE RED TAPE FOR DOCTORS

THURSDAY, OCTOBER 19, 2023

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123, Rayburn House Office Building, Hon. Brett Guthrie, [Chairman of the Subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Johnson, Bucshon, Hudson, Carter, Dunn,

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Pence, Crenshaw, Joyce, Harshbarger, Miller-Meeks, Obernolte, Rodgers [Ex Officio]; Eshoo, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, and Pallone [Ex Officio].

Staff Present: Jolie Brochin, Clerk, Health; Sarah Burke, Deputy Staff Director; Corey Ensslin, Senior Policy Advisor, Health; Seth Gold, Professional Staff Member, Health; Sydney Greene, Director of Operations; Nate Hodson, Staff Director; Tara Hupman, Chief Counsel; Peter Kielty, General Counsel; Emily King, Member Services Director; Chris Krepich, Press Secretary; Lydia Abma, Minority Policy Analyst; Keegan Cardman, Minority Staff Assistant; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Saha Khaterzai, Minority Professional Staff Member; Una Lee, Minority Chief Health Counsel; Avni Patel, Minority Health Fellow; and Andrew Souvall, Minority Director of Communications, Outreach, and Member Services.

*Mr. Guthrie. The subcommittee will come to order.

And the chair will recognize himself for five minutes for an opening statement.

However to say there are a lot of fluid things happening in the whole House today between both sides, and so we are going to have to try to manage this hearing as we move forward.

And thank you, everyone who is testifying, first, and, second, for patience and willingness to work with everyone. We appreciate that.

I will recognize myself for an opening statement.

STATEMENT OF THE HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

*Mr. Guthrie. Today we are considering legislation aimed to provide greater access to care for seniors, including lower cost prescription drugs, as well as reducing unnecessary red tape for health care providers.

We are also considering proposals designed to make updates to our physician reimbursement models that strike the critical balance between driving higher quality care while ensuring the Medicare Program remains solvent for future generations.

According to a September 2023 report, the Centers for Medicare and Medicaid Service, spending on health care is expected to grow faster than GDP over the next decade. This is simply unsustainable, especially for our Medicare Program.

The data show per person health care spending of those over 65 costs on average almost 2.5 times more than the average working person spends, with the Federal Government picking up much of the higher share of the spending.

Their support only further underscores the need for today's hearing and to examine policies intended to sustain and strengthen the Medicare Program.

This is the first time in several years that we have thoughtfully examine our reimbursement system for physicians, many of whom are providing specialized care for seniors with chronic conditions. These conditions also require coordinated care that spans across multiple providers and clinical staff, requiring very targeted reimbursements that incentivize meeting higher quality standards for these patients.

These are complicated problems, and they require serious solutions. Our goal is figuring out how to preserve best access for seniors in a sustainable and responsible manner.

This will require constructive work between stakeholders, regulators, and this subcommittee. Any changes we ultimately pursue will be fully offset and promote the highest quality of care for our seniors.

I want to thank our witnesses for being here today in our first panel, and I will yield my remaining time to the

vice chair of the subcommittee, Dr. Larry Bucshon.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you, Mr. Chairman.

This hearing means a lot to me. As a provider myself, many of the issues on today's agenda are priorities of mine.

Ensuring patients have access to quality providers is the most fundamental reason why I came to Congress in the first place.

I want to talk for a moment about why this hearing is so important. Providers choose to work in health care because they care about people. They invest years, often decades of their lives to training, and then they work grueling hours, many of them.

They sacrifice time for themselves and time for their families to take care of patients. And while they are working, they have the lives of others in their hands which can be incredibly stressful.

We owe it to these providers and their patients to allow them to focus on patient care, not worry about the massive amounts of paperwork waiting for them at the end of the day or about the long-term ability to operate their practice.

We know Medicare is the single largest payer for health

care services in this country and often shapes how private plans approach coverage. It is critical that we ensure Medicare operates in a way that supports providers, thereby ensuring that the millions of seniors who rely on Medicare continue to have access to their doctors.

My passion for this issue is why I have worked for many years to get the Improving Seniors Timely Access to Care bill across the finish line to remove certain prior authorization restrictions from Medicare Advantage. It is why for years I have led the charge in bipartisan efforts to ensure that physicians are reimbursed appropriately, including H.R. 2474, to provide them with inflationary updates to reimbursement levels.

And it is why I believe strongly that we must pass legislation to promote value-based care, as was intended when Congress passed MACRA, the Medicare and CHIP Reauthorization Act in 2015.

I hope my colleagues will join me today in recognizing the importance of these issues and commit to working with me and others on this committee to ensure provider access for Medicare patients.

Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back.

The chair will now recognize the gentlelady from California, Representative Eshoo for five minutes for an opening statement.

STATEMENT OF THE HON. ANNA ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

*Ms. Eshoo. Thank you, Mr. Chairman.

I think I speak for all of us to say it feels good to be back in our hearing room doing our work. So it is good to be with all of you.

Last year my constituent and the president of the California Medical Association, Dr. Donaldo Hernandez, wrote a letter to me saying that, quote, "Within our health care system, a crisis of grave proportions is taking shape,'' unquote.

It was November 2022, while COVID cases had eased. Health care workers were still struggling to keep up. "For us and the patients we serve,'' Dr. Hernandez wrote, "the crisis is far from over.''

The California Medical Association surveyed its members about how Medicare payments are impacting access to care, and the responses were really striking and, I think, highly instructive.

Eighty-seven percent of physicians said low Medicare

reimbursement rates negatively impact their ability to recruit and retain physicians, and 76 percent of physicians said Medicare payments did not cover the cost of providing care.

A few bills we are considering today attempt to stabilize doctors' Medicare reimbursement, although we are notably not considering Dr. Bucshon's and Dr. Ruiz's H.R. 2474, to provide a Medicare physician payment update tied to inflation. I think that that is really a must on a bipartisan basis.

I also often hear from physicians in my district about administrative burdens from Medicare and commercial health insurers. For example, seven years ago Congress passed MACRA, or the Medicare Act and CHIP Reauthorization Act, as Dr. Bucshon said, to finally end the annual need to pass the doc fix, to save doctors from cuts to Medicare reimbursement.

That legislation created the merit-based incentive payment system, which the GAO found added more administrative burden while doing little to improve quality of care. I think our subcommittee should seriously consider

MedPAC's recommendation to eliminated the merit-based incentive payment system.

While traditional Medicare increased its paperwork through MACRA, Medicare Advantage plans also started burdening doctors by overusing prior authorization. Prior authorization has morphed into a costly, inefficient mechanism that prevents patients from receiving care, and it adds unnecessary burdens onto providers and is why I support the Improving Seniors' Timely Access to Care Act, to reduce the overuse of prior authorization in Medicare Advantage plans.

While this hearing is focused on improving patient access to care and reducing burdens on physicians, I am concerned that my Republican colleagues once again are not considering legislation to fund State health insurance programs and the Area Agencies on Aging. These are two programs whose funding expired on September 30th.

And as I said, not that you would remember it, at our last hearing, California State Health Insurance Program is called HICAP. This is a program that works, and it works very, very well. It provides stellar services every day for

seniors in my district who have Medicare problems, and we should not allow this to expire.

I am also concerned that our subcommittee is once again considering a huge slate of bills, 23 in total, with nearly half either in discussion draft form or only formally introduced a week ago.

I look forward to hearing from our witnesses today on how we can enhance beneficiary access to care and reduce burdens on physicians without jeopardizing the financial sustainability of the Medicare Program.

Ten thousand Americans age into Medicare every single day. So if that is not reason enough to find a solution to these issues, I do not know what is.

So thank you, Mr. Chairman, and I yield back.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. The gentlelady yields back.

And I will now recognize the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

STATEMENT OF THE HON. CATHY McMORRIS RODGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

*The Chair. Thank you, Chair Guthrie.

Good morning, everyone. Our focus today is to explore solutions to improved Medicare payments to providers and ultimately help patients.

Everyone has been hurt by inflation, driven by President Biden and the Democrats' record spending spree. Just last week we got two more pieces of bad news on inflation.

First, Medicare Part B premiums are increasing by almost six percent next year. In fact, since President Biden took over, Medicare premiums are up nearly 18 percent.

Next, we found out that core inflation metrics show prices continuing to increase by four percent over last year. "Bidenflation'' remains a huge problem. Everyone from patients to providers is feeling the pain of higher prices and higher interest rates.

Patients have less money to spend on basic needs, food, housing, health care. And for providers, the cost of

running an independent practice is growing as well.

This committee has heard testimony that the whole health care system becomes more expensive when providers cannot afford to stay independent.

Today's hearing will focus on how we can eliminate unnecessary red tape and, more importantly, sustain access to care and lower cost for Medicare beneficiaries regardless of where they live.

As many of my doctor colleagues have said, it is important to let doctors do what they do best, spend time seeing patients and less time filling out paperwork.

The challenge before us is how to balance the need to ensure patients and Medicare are accurately paying for that care, while recognizing that paperwork, even if well intentioned, can limit time spent on providing health care and increases cost.

As we look to modernize our Medicare payment system, we must be thoughtful in striking the best and right balance. Today we will consider a wide range of discussion drafts and legislation that aims to support Medicare providers as they deal with rising paperwork, rising inflation, and rising

labor cost.

For example, a few discussion drafts address expiring payment initiative. If Congress does not act before the end of the year, doctors in certain rural areas and laboratories will see a pay cut from Medicare starting January 1st.

In the short term, Congress should act to avert these cuts, but we should consider why we are having the conversation every single year.

If we need further proof that government should not intervene in the economy, look no further than the physician fee schedule. In our efforts to create a more perfect price control, Congress has increased Medicare payments to doctors seemingly every single year since 2003. I am not saying that these are not worthy endeavors. I believe in supporting our doctors.

In 2015, this committee and Congress passed MACRA to get us out of the cycle of the annual fixes. Yet here we are with a system that again has underperformed those who rely on the Medicare Program.

And still some of my colleagues across the aisle would expand such a system to cover every patient in the country.

The fact is politicians and bureaucrats will always do a worse job than the market at determining the most efficient prices for an item or service, and Congress should spend its efforts on long-term reforms to the program we have now so we are not back at this every one, two, or three years.

It is also important that we recognize the greater context of this discussion. Parts of Medicare are on pace to be insolvent by 2031. Solutions like the bipartisan Lower Cost, More Transparency Act will save Medicare money in the long run.

But our resources are finite, and we must make sure that we are examining every dollar Medicare spends and making sure that it is going to the right places before assuming additional resources are necessary. If additional resources are necessary, we should work together to find ways to save Medicare money in other areas.

Again, our goal today is to strengthen the Medicare Program and increase seniors' access to care by improving the way we reimburse providers.

And I thank our witnesses for being here today, and I look forward to the conversation.

I yield back, Mr. Chairman.

[The prepared statement of the Chair follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. The gentlelady yields back.

I now recognize the ranking member of the full committee, the gentleman from New Jersey, Representative Pallone for five minutes.

STATEMENT OF THE HON. FRANK PALLONE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

*Mr. Pallone. Thank you, Mr. Chairman.

It is now Day 17 of the House being paralyzed without a Speaker, and we are 29 days away from another potential government shutdown. This hearing comes at a time when House Republicans' disfunction is hurting the American people, weakening our economy, and undermining our national security.

All year House Republicans have caved to the extreme elements in their party who have no interest in governing. They have forced severe cuts to critical Federal programs in spite of a funding agreement between the former Speaker and President Biden, and they came dangerously close to a government shutdown that would have cost our national economy upwards of $13 billion a week and forced our troops to work without pay.

I just think the American people deserve better. Democrats have repeatedly stopped this chaos and disfunction from hurting every day Americans, but it is long past time

for House Republicans to reject the extremists in their party.

We should be working together to lower costs for American families and to grow our economy and the middle class. It is time for the chaos to end.

Now, turning to the topic of today's hearing, Medicare has played a critical role in the lives of our Nation's seniors and disabled Americans since its enactment. Medicare is the main source of health care for most of our Nation's seniors and disabled individuals, and we must ensure it remains sustainable long term and delivers the highest quality care.

I have major concerns about the process leading up to today's hearing. My Republican colleagues shared a vast majority or the discussion drafts we will be discussing less than a week before the hearing was noticed. Many of these drafts are still half-baked, and given the broad array of topics in bills, I am disappointed that we did not have adequate time to fully vet some of these policies and provide Democratic input from the beginning.

The Republican majority has also put forward a long

list of expensive Republican-led bills that could collectively cost billions of dollars without any proposed way of paying for them, and this is especially ironic given that just yesterday in a speech on the House floor nominating Jim Jordan as their candidate for Speaker, Republicans expressed concern with Medicare's finances and cited their support for Jordan because of his desire to make devastating to our Nation's social safety net health care program.

It is unfortunately a pattern we see over and over again from Republicans, pushing forward expensive policy changes and then demanding devastating spending cuts to Medicare that would increase costs for seniors.

The truth is Medicare is not broke. It does not need major changes, and it certainly does not need terrible Republican ideas to cut benefits, raise the retirement age, or increase seniors' cost contributions.

What we need is for Republicans to stop their in-fighting so Congress can come together and find bipartisan solutions for the American people.

Now, while some of these policies before us today may

have merit and address critical needs of both Medicare patients and providers, unfortunately my Republican colleagues have thus far refused to engage with us constructively or propose a path forward to move these bills on a bipartisan basis.

Given the Republican Majority's unproductive record on the House floor this Congress, I remain concerned that we are not going to be able to successfully move a bipartisan legislative package out of committee onto the House floor and to the President's desk.

My Republican colleagues also rejected committee Democrats' sole request to include legislation in today's hearing that would directly expand access to care and reduce health care costs for seniors. The Majority refused to include H.R. 5630, the Helping Low-Income Seniors Afford Care Act, led by Representative Craig. The bill would directly expand coverage for seniors and lower their out-of-pocket costs by extending funding for outreach and enrollment programs. These programs help low income Medicare beneficiaries enroll in Medicare and access benefits that lower their out-of-pocket costs.

Thanks to these programs about 3.5 million Medicare beneficiaries have received assistance, and the number of seniors enrolled in the low income subsidy program increased from 11.8 million in 2014 to 14.2 million in 2020.

Now, let me just say I am concerned that the totality of these proposal would result in significant funding cuts to the Medicare Program and raise health care costs for seniors through increased premiums. This will place additional undue burdens on our Nation's seniors and raise their out-of-pocket costs.

Democrats stand united in opposition to any Republican efforts to cut Medicare benefits, raise the retirement age, or increase seniors' cost sharing or premiums, and we will continue the fight to protect the Medicare Program.

And I thank all of our witnesses for being here today.

And I yield back, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. The gentleman yields back.

That concludes opening statements. We will now turn our panel for the opening statements of our panel.

I will introduce each panel member, and then we will begin with you Dr. Seshamani.

So four first witness, Dr. Meena Seshamani, Director of Centers for Medicare and Medicaid Services.

Ms. Leslie Gordon, Director of Health Care at the Government Accountability Officer.

And Mr. Paul Masi, Executive Director of the Medicare Payment Advisory Commission.

So, Dr. Seshamani, you are recognized for five minutes for your opening statement.

STATEMENT OF DR. MEENA SESHAMANI, DIRECTOR, CENTER FOR MEDICARE, CENTERS FOR MEDICARE AND MEDICAID SERVICES; LESLIE GORDON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; AND PAUL MASI, MPP, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

*Dr. Seshamani. Thank you.

Chairs McMorris Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and members of the subcommittee, thank you for the opportunity to discuss the Centers for Medicare and Medicaid Services' efforts to improve the Medicare Program.

Before becoming the Director of the Center for Medicare, I took care of patients as an ear, nose, and throat physician. I saw firsthand the powerful impact that health care can have on health and wellbeing of individuals and their communities, and I bring these stories with me to my current role now.

Our goals for Medicare include driving high quality whole person care, improve access to coverage and care, advancing health equity, and improving affordability and

sustainability of the Medicare Trust Fund.

And all of this is only possible through robust engagement with our partners and the communities we serve.

Medicare payment policy is set in statute by Congress, and CMS works within the confines of the law to establish payment policies for physicians and other health care professionals.

One area of focus for us is transforming care through more holistic models where health care providers can care for people, not just treat a disease.

Over the last decade, Medicare has accelerated participation in value-based care models that reward better care, smarter spending, and improved outcomes.

In 2022, the Medicare Shared Savings Program saved Medicare roughly $1.8 billion compared to spending targets for the year. This marks the sixth consecutive year of net savings, while the participating accountable care organizations, or ACOs, maintained higher ratings for quality of care than similarly sized physician groups.

In July 2023, CMS proposed changes that would help grow the Medicare Shared Savings Program in order to improve

access to coordinated, efficient, and high-quality care for more people with Medicare.

Many of these changes were suggested by those providers currently participating in the program or by those who wanted to participate but felt they could not, particularly providers in rural and underserved areas.

We have also prioritized expanding access to care, particularly in behavioral health and telehealth, which is critical to improving the health and wellbeing of Medicare beneficiaries.

Following congressional action, CMS has proposed procedures to allow marriage and family therapists and mental health counselors to enroll in Medicare in order to independently treat people with Medicare and be paid directly.

CMS has also proposed payments for intensive out-patient program which, if finalized, would close a critical gap in the types of behavioral health services covered by Medicare.

Following congressional actions, Medicare also permanently expanded access to telehealth for behavioral

services, including audio only services for people who lack access or are unable to use video, and we know that telehealth services have enabled individuals in rural and underserved areas to have improved access to care.

CMS will continue to work within the confines of the law to ensure Medicare appropriately covers these critical services.

We remain concerned about the profound health inequities that have persisted in the United States for generations.

CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all people served by our programs by incorporating the perspective of lived experiences and integrating safety net providers and community-based organizations into our programs.

And finally, CMS is working to ensure that Medicare remains affordable for people and sustainable for future generations.

The Inflation Reduction Act makes improvements to Medicare by expanding benefits, lowering drug costs, and

improving the sustainability of the Medicare Program for generations to come.

The law provides meaningful financial relief for millions of people with Medicare by improving access to affordable treatments and strengthening Medicare both now and in the long run.

Moving forward, we aim to continue to collaborate with Congress and our other partners on areas where we can work together to drive meaningful change in the health care system.

We are committed to ensuring we integrate the perspective of the communities that Medicare serves as well as the providers and health plans that deliver health care into our policies.

So thank you again for the opportunity to testify today, and I am happy to address any questions you have.

[The prepared statement of Dr. Seshamani follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. I thank you for your testimony.

The chair now recognizes Ms. Gordon for five minutes for your opening statement.

STATEMENT OF LESLIE GORDON

*Ms. Gordon. Good morning, Chair Guthrie, Rodgers, Ranking Member Eshoo, and Pallone, and members of the subcommittee.

I am pleased to be here today to discuss issues that affect physician payments and experiences in traditional fee-for-service Medicare.

With Medicare enrollment and spending projected to increase, controlling program spending remains a serious long-term financial challenge. Physicians and other providers play a central role in the growth of Medicare expenditures, both through the services they provide and the services they order, such as diagnostic tests and referrals.

My statement summarizes three of GAO's most recent reports that examine the geographic payments adjustments for services under the physician fee schedule and physicians' and other providers' participation in and experiences with the merit-based incentive payment system and advanced alternative payment models.

First, in February 2022, GAO reported on geographic

adjustments to physician payments for physicians' time, skills, and efforts focusing on geographic adjustment to the physician work component under the fee schedule.

The purpose of these adjustments is to account for differences in the cost of providing care across various geographic locations. Specifically, Medicare will pay more for a service in an area where approximate costs for a physician's time, skills, and effort are higher than the national average and less in an area where costs are lower.

GAO reported in 2022 that modeling for the geographic variation generally accounted for physician earnings in 90 of 119 localities that we examined. However, in 14 localities, the adjusted value was below the level needed to reflect the geographic variation in physician earnings, and in 15 localities the adjusted value was above.

We also reported that removing the physician work geographic floor would decrease overall payments by about $440 million in a year, less than one percent of physician payments as of 2018, when we looked at that, and most of the affected payment localities would see less than a two percent decrease.

Turning my attention to the Quality Payment Program in 2021, we reported on physicians' and other providers' experience under the merit incentive payment system looking at the year 2017 through 2019.

The merit based incentive payment system allows eligible providers to earn performance-based payment adjustments. We found that at least 93 percent of providers qualified for a positive payment adjustment. Less than five percent qualified earned a negative adjustment.

And since few funds were available to spread out across the large number of providers who earned positive adjustments, those positive adjustments were less than two percent.

In November 2021, we reported on the physicans' and providers' participation in advanced alternative payment models again from 2017 to 2019. The advanced alternative payment models encourage providers to share in the financial rewards and risks of caring for beneficiaries.

We reported that the proportion of eligible providers who participated was lower among providers in rural health professional shortage areas and other underserved areas

compared to the other providers.

Most providers, however, who participated regardless of the area were eligible to earn the five percent incentive payment regardless of practice.

That summarizes the high level notes from those three reports that we recently issued, and this concludes my prepared remarks.

I would be very happy to answer any questions you may have.

Thank you.

[The prepared statement of Ms. Gordon follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. I thank you for your testimony.

The chair now recognizes Mr. Masi for five minutes for an opening statement.

STATEMENT OF PAUL MASI

*Mr. Masi. Chair Guthrie, Chair Rodgers, Ranking Member Eshoo, Ranking Member Pallone, distinguished committee members, my name is Paul Masi, and I am the Executive Director of the Medicare Payment Advisory Commission.

I am grateful for the opportunity to be with you today to discuss how to ensure patient access to care and minimize burden for providers.

MedPAC does not take positions on proposed legislation, but I am happy to provide information about relevant commission work that may be helpful as the committee considers these issues.

As you know, MedPAC is a nonpartisan congressional support body. So our mission is to help you with the difficult decisions you must make each year. We have 17 commissioners, all appointed by GAO. Ten of our commissioners have clinical training, including eight physicians, a registered nurse, and a registered pharmacist.

Nine of our commissioners have high level executive

experience with health care delivery organizations and plans, and eight commissioners are academic experts who publish frequently in peer-reviewed journals, and some have more than one of those credentials.

The commission is also supported by a terrific staff with deep expertise analyzing Medicare issues of payments, access, and quality.

I mentioned the credentials to emphasize that the commission has experience in different aspects of the Medicare Program and our goal is to bring that experience to bear to help the Congress improve the program for patients, taxpayers, and providers.

Now, just because we have that experience that does not mean we have all the answers, but you can be assured that our agenda as a commission is the same as yours: high quality care for Medicare beneficiaries at the lowest cost for taxpayers.

A core part of MedPAC's statutory mission is assessing whether overall payments in fee-for-service Medicare are adequate to ensure that Medicare beneficiaries have access to high quality care and to advise Congress on what steps to

take when payments are too low or too high.

Overall, MedPAC has found that Medicare beneficiaries have access to clinician services that is comparable to privately insured patients. We do several things to arrive at that finding.

We field our own nationally representative survey of Medicare beneficiaries. We conduct focus groups with beneficiaries in urban and rural areas and focus groups with clinicians. We analyze Medicare data, and we compare all of our findings with other surveys and researchers.

Based on that assessment for the last several years the commission recommended that the amounts in current law were sufficient to support continued access to clinician services.

However, this March, the commission made two recommendations to Congress on how to update Medicare's payments under the fee schedule.

First, the commission recommended that for 2024, Medicare payments under the fee schedule should increase by one-half of the Medicare economic index, which is a measure of inflation. That reflects concern for how recent

inflation has affected the costs of running a physician practice.

And, second, the commission recommended an add-on payment for clinicians who treat low-income Medicare patients. This recommendation would target additional resources to support access for the most vulnerable Medicare patients and the providers who serve them.

That was based on evidence that those patients can face barriers to care and be more expensive to treat.

This is one example of an important commission principle. Policy solutions should be evidence based and targeted to address specific problems to ensure that Medicare's resources are used efficiently.

Lastly, the commission recognizes the importance of reducing red tape for providers because their time is best spent focusing on patient care. Reducing administrative burden was one of the key reasons why in March 2018, the commission recommended that MIPS be eliminated.

The commission found that MIPS was burdensome for providers, unlikely to collect meaningful information on quality, and would make inequitable payment adjustments.

Now, the commission supports other elements of MACRA that replace the SGR and encourage comprehensive, patient-centered care delivery models.

Looking ahead, the commission has ongoing work on several of these issues. In our October public meeting, commissioners discussed alternative approaches to updating payments under the fee schedule and the future of the APM bonus.

Additionally, in our December and January public meetings, we will include updated information about beneficiary access to care and payment recommendations to ensure continued access.

The commission is happy to continue being a resource to the committee, and I look forward to your questions.

[The prepared statement of Mr. Masi follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you for your testimony.

That concludes all of our witnesses' testimony, and we will begin the questioning period, and I will recognize myself for five minutes for questions.

First, I want to say I appreciate the passion from my friend from New Jersey. We are not proposing anywhere in there to take benefits away, nor are we proposing to pay more.

We were just as passionate fighting what did happen last Congress where the Inflation Reduction Act, not only was it the policy of Medicare Part D. We think we are going to hurt innovation for our seniors, but also the scored savings _ and I do not say "savings'' _ the scored savings from CBO were spent, outside of all these issues we are going to talk about today, was spent outside of Medicare to enhance subsidies to help insurance companies.

People need to understand we were just as passionate fighting that as he talked about, and so we need to come together to help our seniors with the Baby Boomers coming forward, retiring, and make sure Medicare is sustainable going forward.

When they spent the money on the enhanced subsidies for health insurance companies, they knew this was coming, and they chose to spend the money there. So I just want to make that point, as passionate as he made his.

So, Ms. Gordon, your reporting suggests that there are significantly more providers enrolled in the merit-based Incentive Payment Program versus enrollment in advanced Alternative Payment Models.

What do you believe are the primary drivers for why there was such a big gap between enrollment in these two programs?

And in your estimation, which program has been more impactful from the perspective of driving more efficient spending and outcomes for patients?

*Ms. Gordon. So we reported that there were a large number of providers enrolled in the MIPS Program compared to the advanced APMs. Structurally the two programs are different.

So clinicians are eligible for MIPS and they are, you know, requested to and required to participate, whereas APM is a voluntary program.

And there are higher barriers, sort of more up-front costs and more investment that needs to be made to enroll in the advanced APM.

So I would believe that that might be why we see greater enrollment in the MIPS compared to the APMs.

*Mr. Guthrie. So which program do you think would be more impactful and efficient spending?

*Ms. Gordon. We have not evaluated that. We have heard from stakeholders with regards to both programs that there were challenges.

With MIPS, the challenges have to do with is it really driving meaningful quality improvements. The metrics that were reported in the time that we looked at it, from 2017 to 2019, were not necessarily for the larger practices, the quality measures were not necessarily indicative of the specialties that could be encompassed in a multi-special practice.

With the APMs, we also saw some challenges in the up-front cost.

*Mr. Guthrie. Okay. Thank you.

And, Dr. Seshamani, do you believe rebates ought to be

considered for the purposes of determining the net price as CMS selects drugs for price negotiation?

*Dr. Seshamani. Thank you for your question.

We are implementing the Inflation Reduction Act and the Drug Price Negotiation Program consistent with the law and incorporating all of the feedback that we have gotten and will continue to get through the robust engagement with all interested parties.

We laid out in our guidance for the negotiation program that we will be looking at the factors that are laid out in the inflation _

*Mr. Guthrie. What about rebates specifically? Should they be considered in the net price, the rebates?

*Dr. Seshamani. In the net price in the Part D?

*Mr. Guthrie. Determining the net price, should the rebates be considered?

*Dr. Seshamani. In terms of how PBMs and manufacturers negotiate with each other, the law is clear that we are prohibited from interfering with that process, and we follow the law and implement consistent with the law in terms of the administration of the Part D program.

*Mr. Guthrie. Well, there is some question up here about how that should be implemented, but maybe that is something we need to address on our side of this hearing.

So, Dr. Seshamani, what are your primary goals in implementing the new merit-based incentive payment system, value pathways, the MIPS value pathways program?

And what more do you believe needs to be done to drive more enrollment in APMs?

*Dr. Seshamani. Thank you for that question.

The merit-based incentive payment system is administered by my colleagues in the Center for Clinical Standards and Quality, and what I can say is that we are very interested in driving participation in value-based care and looking across our programs to be able to align quality metrics so that we can really galvanize momentum to drive change on the ground.

And we would be interested in continuing to work with you on this issue.

*Mr. Guthrie. Okay. I would ask another question, but I have only got five seconds. I am going to stick right to five because we are going to try to get as many people in as

we can moving forward.

So I will yield back and recognize the ranking member from California for five minutes.

*Ms. Eshoo. Thank you, Mr. Chairman.

And thank you to each one of the witnesses.

I am frustrated. There are two things that I deal with consistently in my congressional district, and I do not think my congressional district is unique.

Number one, doctors are not reimbursed with fair compensation. Therefore, they drop out. They cannot afford to be in the Medicare Program.

And then the Medicare beneficiaries in my district, they cannot find increasingly, with great difficulty, find a doctor that accepts Medicare patients.

So, you know, I know that we have the responsibility in terms of statutes, certainly the funding mechanisms. We are going to have to figure out how we pay doctors fairly, well, so that it is fair, but also in the public interest that they will stay in Medicare and treat patients.

Now, most Medicare patients are not very sick. So in these measurements that you have done, it really is, I

think, for those that are very sick. So I am not so sure what you have studied.

I think we need to measure what matters, and I think that those two bookends, so to speak, that I have just raised are at the heart of what we need to address in our country because when push comes to shove, if you do not have doctors in Medicare, then what can Medicare mean to a Medicare recipient? They are not receiving anything.

So we have got some serious work to do relative to the dollars in this, where we can save money and where we are going to have to raise money. And both of those areas can be uncomfortable, depending on the lens that they look through.

Now, in the March '23 report earlier this year, MedPAC estimated that Medicare spends six percent more for Medicare Advantage enrollees than it would if those enrollees remained in original Medicare. That translates into _ this is now what I am pursuing, is the savings side _ $27 billion, 27 billion, in overpayments this year alone.

So both to Dr. Seshamani and Mr. Masi, first, what action is CMS taking to reduce these overpayments?

And, Mr. Masi, how does MedPAC recommend reducing the excess payments to the Medicare Advantage plans?

Because we have got to look for saving money before we go out to consider where we raise other dollars so that Medicare actually works for Medicare recipients.

*Mr. Masi. Yes, thank you for the question.

And you are absolutely right. Our analysis shows that on average, Medicare pays more for Medicare Advantage relative to fee-for-service. We have a number of recommendations to improve the value that the program gets when it pays MA plans.

I will highlight two very quickly. One, we would change the quality program in MA so that it is budget neutral, like most fee-for-service quality programs, and also restructure it to get more meaningful quality information for when beneficiaries pick different plans.

And, number two, we have recommendations to address coding that on average MA plans code more intensively, and that _

*Ms. Eshoo. I did not hear you, and I am hanging on every word.

*Mr. Masi. I am sorry.

*Ms. Eshoo. Because you are talking about $27 billion in one year alone.

*Mr. Masi. Yes. And the second recommendation I would highlight is we would address coding where Medicare Advantage plans code more intensively than fee-for-service, and that increases program spending, and it also increases Part B premiums for beneficiaries. And we have some ideas for how to address that.

*Ms. Eshoo. Doctor, are you paying attention to those recommendations?

*Dr. Seshamani. Yes, and thank you for your _

*Ms. Eshoo. Do you accept them, reject them? What is happening?

*Dr. Seshamani. Thank you for your question.

We share your goals of access to care and affordability and sustainability for the Medicare Program, and payment accuracy is an important aspect of that.

In our recent _

*Mr. Guthrie. I think both groups have conferences coming up really quickly. So we are going to have to try to

stay to the five minutes.

*Ms. Eshoo. Okay.

*Mr. Guthrie. We will get the answers.

*Ms. Eshoo. We will get your answer in writing _

*Dr. Seshamani. Absolutely.

*Ms. Eshoo. _ so you can give me a lot of good information.

How is that?

Thank you.

*Mr. Guthrie. The gentlelady yields back.

And the chair recognizes the chairwoman of the full committee for five minutes.

*The Chair. Thank you, Mr. Chairman.

This is an important hearing. It has been four years since we have had a provider hearing. So I am anxious to get to work.

CBO recently released a report projecting Federal spending on Medicare will almost double over the next ten years, from 813 billion in fiscal year 2023 to over 1.5 trillion in 2033, alone.

Medicare Part B, which includes physician services,

out-patient services, and physician administered drugs, accounted for the largest share of Medicare benefit spending, 48 percent in 2021.

Dr. Seshamani, I did not see any proposals in the President's fiscal year '24 budget regarding spending on physicians in Medicare Part B, either to make sure that there is access in rural areas or reduce red tape to make sure that it is easier for physicians in Medicare.

Would you speak to whether or not the administration thinks that the status quo is acceptable for seniors right now and ten years from now?

*Dr. Seshamani. I appreciate you raising this.

It is a shared goal for us to ensure access to care for people in Medicare, quality care, and to make sure that the program is sustainable.

Congress sets payment policy, and we implement that consistent with the law, and some of the areas that you raised are things that we have taken into consideration in our regulatory authority to do things about. So, for example, rural health, that is a priority for us.

I personally, in my prior role, took care of people in

a rural area. I also have traveled through the country visiting providers in rural areas, and I know how critical it is that we ensure access to care there.

And we have implemented the rural emergency hospital.

*The Chair. Thank you. Okay.

I will be looking for the specifics. Okay? And we will have to follow up.

The Medicare Trustees report from this year discussed how more hip and knee replacements being paid through Medicare Part B instead of Medicare Part A has contributed to Medicare Part A solvency projections being pushed out a few years.

Are there other services CMS thinks could safely be done in out-patient settings and what levers should Congress look at encouraging being performed in the lowest cost setting while maintaining quality and service?

*Dr. Seshamani. Thank you for that question.

We share the goal that people should obtain the care they need in the setting that is appropriate for them, and we will continue to analyze data, as you mentioned, and we will be happy to continue working with you on this.

*The Chair. Okay. Thank you.

I hear from doctors in my district about how rising inflation and red tape is making it harder and harder for them to stay in independent practice, and this committee heard testimony this spring about consolidation in the health care system being one of the driving factors leading to increased health care cost.

Mr. Masi, my understanding is that hospitals get increases for inflation but doctors do not. Can you talk about why that is and how Medicare payment systems differ?

*Mr. Masi. Thank you for the question.

That is correct. There are differences between how Medicare sets and updates payments for physician services and how Medicare sets and updates payments for hospitals. Part of the reason may have to do with the unit of payment is more disaggregated under the physician fee schedule where, as you know, Medicare will pay for more than 8,000 different items and services under the fee schedule.

And in the past, Congress has enacted policies that have tried to address incentives for volume under the fee schedule.

*The Chair. Would you speak to how often those increases for inflation are calculated for hospitals versus doctors?

*Mr. Masi. Yes. So under the in-patient prospective payment system which updates payments for hospitals, hospitals do receive an inflation update every year.

In the past, the commission in part of monitoring access to Medicare beneficiary access to care, we have tended to find that the updates under the fee schedule have been sufficient to continue access, but this year, as I talked about, was different, and we did recommend that payments under the fee schedule should be updated by a portion of inflation.

*The Chair. What are your projections for the next ten years?

*Mr. Masi. Thank you for the question.

This is an issue that the commissioners discussed in their October public meeting. This is a very important line of work, and we are going to be continuing it in the coming months.

*The Chair. Okay. More questions to come. I have run

out of time.

I yield back.

*Mr. Guthrie. The Chair yields back.

And the chair now recognizes the gentleman from New Jersey for five minutes for questions.

*Mr. Pallone. Thank you, Mr. Chairman.

Medicare is the main source of health care for our Nation's seniors and individuals with disabilities, and I will continue the fight to protect them Medicare Program. I am extremely disappointed that my Republican colleagues rejected my sole request to include S.360 today, which would directly expand access to coverage and lower health care costs for our Nation's most vulnerable low-income seniors.

The legislation would reauthorize and extend funding of critical outreach and enrollment programs, including the State Health Insurance Program, SHIP, which helps our Nation's seniors enroll in Medicare and receive assistance for prescription drug coverage that lowers their out-of-pocket cost.

Many of these seniors live on fixed incomes and struggle to afford lifesaving drugs. So I wanted to ask Dr.

Seshamani can you briefly discuss the importance of these outreach and enrollment programs, including SHIP, and how they help millions of low-income seniors?

*Dr. Seshamani. Thank you for raising this.

Outreach is so important in the Medicare Program because ultimately, we want to make sure that people are able to navigate the program, choose the option that works best for their health and financial needs so they can take advantage of the benefits that are available.

And the SHIP Program is one aspect of our overall, and a very important aspect, of our overall outreach, to also include our Medicare.gov, 1-800-Medicare, and all of the work we do with our community partners during open enrollment and at other times of the year.

*Mr. Pallone. Well, thank you, Doctor.

Now, millions of seniors qualify for the Medicare Savings Program, MSP, and the Low-Income Subsidy, LIS Program, which directly lowers seniors' out-of-pocket costs. Without these programs, many seniors simply could not afford the care they need.

So let me ask you. I understand that these low-income

outreach and enrollment activities help senior enroll in LIS and access the assistance to help with their out-of-pocket drug costs; is that correct?

*Dr. Seshamani. Yes, and thanks to the Inflation Reduction Act, the low income subsidy program is expanding starting January 1st, 2024, and that is a priority for us as we are in Medicare open enrollment now, to make sure that people know that they should find out if they could be eligible for that assistance.

*Mr. Pallone. And I also understand that up to three million low-income seniors and individuals with disabilities qualify for LIS but are currently not enrolled; is that correct?

*Dr. Seshamani. It is correct that there are definitely across our programs people who are eligible who are not enrolled, and that is why outreach is a priority for us.

*Mr. Pallone. Well, thank you.

I just think we have to expand and extend these programs so that more low-income seniors and individuals with disabilities will be able to access the help that they

need.

We know that these outreach and enrollment programs are successful as they have already provided assistance to millions of seniors and have contributed to increased enrollment in both MSP and LIS.

And I am, again, extremely disappointed that the Republican Majority refused to notice these important programs that have longstanding bipartisan support and that have been extended 11 times over the past 15 years.

It is critical that we reauthorize and extend funding to these programs and hopefully we will be able to accomplish that at some point soon.

So thank you, Doctor.

And I yield back.

*Mr. Guthrie. The gentleman yields back.

The chair now recognizes the gentleman from Texas, Dr. Burgess, for five minutes.

*Mr. Burgess. Yes, and I need to start off with a couple of unanimous consent requests. I have got statements from the American Medical Association, the American Osteopathic Association, and the American Association of

Urologists in support of some of the draft bills that I have included in today's hearing.

I have got another study from the Physicians' Advocacy Institute detailing how physician-owned hospitals promise savings of more than a billion dollars a year for 20 expensive conditions.

And then finally an article from the Washington Post from September of this year about how Medicare spending per beneficiary has leveled off for more than a decade.

And I ask unanimous consent to add those to the record.

*Mr. Guthrie. No objection.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Burgess. I do want to thank our witnesses for being here today. This was an extremely important hearing. I have been on this committee for a long time, and I cannot remember us having a hearing specifically on the concept of proposing a legislative change to budget neutrality.

And certainly we hear from docs all over the country that the current Medicare fee schedule is unsustainable and is unpredictable. This is due in part to budget neutrality. This mechanism often leads to across-the-board cuts and makes it harder for independent physicians' practices to survive, and that, of course, threatens access to care.

Three of us who are co-chairs of the Doctors Caucus, myself, Dr. Murphy, and Dr. Wenstrup, plan to introduce the Provider Reimbursement Stability Act of 2023. There is a draft of that as part of today's hearing. This bill would increase the budget neutrality threshold, allowing for corrections for overestimates and underestimates of budget neutrality adjustment and require timely updates to practice expense relative value units.

We have all seen what has happened to the cost of labor. California passed a minimum wage for health care

workers, for doctors who are in practice. They are competing for workers against that same pool of laborers, and again, the word "unsustainable'' continues to creep into the conversation.

I have worked with many people in this room on both sides of the dais and I hope we can get behind some of these commonsense solutions.

So, Mr. Masi, thank you for being here today. Let me just ask you a general question.

Does MedPAC agree that it is important to use timely and accurate data to determine setting rates for the fee schedule, such as clinical labor and supplies?

*Mr. Masi. Thank you for the question.

Yes, the commission would agree that it is very important for Medicare to set payment rates using timely and accurate data on practice expense as well as work.

*Mr. Burgess. So one of the things that has come up today a lot is MIPS versus APMs, and I would just have people recall as we were trying to get rid of the sustainable growth rate formula, there was concern that all doctors would be driven into ACOs and HMOs because that

would be the easy way to approach the problem.

But to allow small practices, one, two, three group practices to continue practicing and to participate in a positive practice update, that was the reason for the merit-based incentive program.

We have had one hearing in the last four and a half years on the implementation of MACRA. We did not have any for four years. Fortunately, with this committee's leadership, Chairman Griffith had an oversight hearing on MACRA.

One of the things that came up in that hearing with a Harvard witness, he suggested that it was not possible for small practices to participate in APMs, but, Mr. Masi, I seem to get from your testimony that that perhaps is a possibility.

*Mr. Masi. Thank you for the question.

The commission agrees it is important to transition providers and give them opportunities to participate in APMs. This is an area that the commission is working on. We discussed the APM bonus in our October meeting, and we are going to continue working on that in the future to see

how it can be restructured.

*Mr. Burgess. And I think it was suggested by Ms. Gordon that enhancing payments so that meeting the necessary informational structure, infrastructure so that would be possible.

I mean, it is a big expense for a small practice, one or two-doctor practice to provide the infrastructure that is going to be necessary to collect the data.

So is that something you are willing to look at?

*Mr. Masi. Yes, of course, the commission is happy to work on this issue and support the committee.

*Mr. Burgess. So we do have to be concerned about the consolidation of small practices, consolidation in health care in general. This is one of the ways that we can tackle that.

Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. Thanks, Dr. Burgess. The time has expired. Thank you for yielding back.

And so what I am going to announce, we are going to have one more set of questions, but there are conferences in caucuses at 11:00. I think there is now a scheduled vote

possibly.

The witnesses will stay in contact with our staff. We will make sure we move forward, but we are going to recess after this question.

So we are balancing both sides. So we have Ms. Blunt Rochester from Delaware. You are now recognized for five minutes for questions.

*Ms. Blunt Rochester. Thank you, Chairman Guthrie and Ranking Member Eshoo for the recognition.

And thank you to our witnesses for your testimony.

Today we are considering health care provider policies, including my bipartisan bill, the Increasing Access to Quality Cardiac Rehabilitation Care Act, H.R. 2583.

And I want to thank my colleague, Representative Adrian Smith, for his tireless work on this bill, and also acknowledge that he worked alongside our late colleague John Lewis on this bill, and I am proud to be taking up the mantle.

This bill will increase patient participation in cardiac and pulmonary rehabilitation programs, two lifesaving services, by authorizing physician assistants,

nurse practitioners, and clinical nurse specialists to order them.

These interventions are proven to reduce mortality rates, hospitalizations, and cost. Unfortunately, they have historically been underutilized due in part to a lack of referrals from physicians and inadequate follow-up after referrals.

Congress attempted to address this issue by authorizing certain additional providers to supervise cardiatric and pulmonary rehabilitation in the bipartisan Budget Act of 2018. However, CMS has indicated that while this policy change is an important step forward, they, quote, "do not anticipate any significant increase in utilization of cardiac and pulmonary rehabilitation services and subsequent impact to the Medicare Program.''

Dr. Seshamani, we all know that these programs reduce mortality rates and hospitalizations and costs, but can you describe why participation remains low in these programs, despite the potential benefits?

*Dr. Seshamani. I appreciate you raising this.

We agree that cardiac and pulmonary rehabilitation are

important and beneficial for Medicare beneficiaries. We looked at literature and studies on utilization rates for the impact analysis of the proposed changes that would implement what you referred to with the bipartisan Budget Act of 2018 to allow PAs and PEs and others to supervise these programs.

And we will continue to monitor utilization of these programs after implementation of this new requirement and can continue to work with you on this issue.

*Ms. Blunt Rochester. Can you just describe how CMS concluded that allowing these groups to supervise these programs without the authority to put in orders may not increase participation?

And what other potential solutions may increase access and utilization of cardiac and pulmonary rehab?

*Dr. Seshamani. We used the literature and studies that were available on the utilization rates, and this points to the need to continue to examine the utilization when these changes are made.

And we would be happy to continue working with you on this as we agree that cardiac and pulmonary rehabilitation

is an important service for Medicare beneficiaries to have access to.

*Ms. Blunt Rochester. Yes. I think what is important here is they need the authority as well.

And so I want to switch to primary care for the minute and 30 seconds that I have left.

Delaware, like other places, is experiencing a shortage in primary care providers, and that is why I am one of the primary sponsors of the bipartisan effort to reauthorize the community health center program and why I serve as one of the co-chairs of the Primary Care Caucus.

In Delaware, we have seen that while physicians, primary care physicians, are accepting new patients, for Medicare and Medicaid it is much lower. And this is a big concern.

So, Dr. Masi, in your testimony, you describe certain financial pressures health care providers face, including primary care providers, that may influence their decision to see Medicare patients.

Can you please highlight a few of those?

*Mr. Masi. Yes. Thank you for your question.

So every year we monitor access that beneficiaries have to health care services, including clinician services. And this year we recommended an add-on payment to target additional resources to help support care.

And the key thing I want to point out is that we structured that add-on payment so that it would be higher for primary care clinicians when they provide services to low-income Medicare patients. We think that is an important way to target Medicare resources, to shore up access.

*Ms. Blunt Rochester. Thank you.

I am going to submit questions for the record, but along that line of implementing G2211 and the add-on, from some we have heard that it is not justified, not resource based; it is costly and duplicative and also leading to overpayment.

So we would like to follow up with you all on your answers regarding that as well.

And thank you so much. I yield back.

*Mr. Guthrie. Thank you.

The gentlelady yields back.

And again, I will remind everyone just we will all stay

in touch and figure out what is moving forward. I think it is unknown exactly what the timing is going to be throughout today. We will make decisions as we know more.

So we appreciate that and appreciate you all being here in the second panel as well.

Current now, the subcommittee will stand in recess, subject to the call of the chair.

[Recess.]

*Mr. Bucshon. [Presiding.] The subcommittee will come to order.

We will now resume with our second panel.

Our witnesses for the second panel today are Dr. _ I have got to put my glasses on. Sorry about that _ Dr. Steve Furr, President-Elect of the American Academy of Family Physicians;

Dr. Debra Patt, Executive Vice President of Texas Oncology;

Mr. Joe Albanese, Senior Policy Analyst for Paragon Health Institute;

And Dr. Matthew Fiedler, the Joseph A. Pechman Senior Fellow in Economic Studies at the Brookings Schaeffer

Initiative on Health Policy at the Brookings Institute.

Dr. Furr, you are recognized for five minutes for your opening testimony.

STATEMENT OF STEVEN FURR, M.D. FAAFP, PRESIDENT-ELECT, AMERICAN ACADEMY OF FAMILY PHYSICIANS; DEBRA PATT, M.D., Ph.D., MBA, EXECUTIVE VICE PRESIDENT TEXAS ONCOLOGY; JOSE ALBANESE, MPP, SENIOR POLICY ANALYST, PARAGON HEALTH INSTITUTE; AND MATTHEW FIEDLER, Ph.D., JOSEPH A. PECHMAN SENIOR FELLOW IN ECONOMIC STUDIES, BROOKINGS SCHAEFFER INITIATIVE ON HEALTH POLICY, THE BROOKINGS INSTITUTION

*Dr. Furr. Chairman Guthrie, Vice Chair Dr. Bucshon, Ranking Member Eshoo, and members of the subcommittee, my name is Steven Furr. I am a practicing family physician in Jackson, Alabama.

I am the co-founder of the Family Medical Clinic of Jackson, which is a rural health clinic, and the Chief of Staff in a small rural hospital and Medical Director of the local nursing home.

As the President-Elect of the American Academy of Family Physicians, I am honored to be here today representing 129,600 physicians and student members of the AAFP.

I went into family medicine over 35 years ago as a

National Health Service Corps Scholar to serve in an underserved community. I went there, paid my dues, did my time, and I did what the program meant to do. I stayed there and continued to serve that community.

I have stayed there ever since. My training has allowed me to develop long-term relationships with my patients and deliver patient-centered primary care.

We are not called family medicine physicians just because we treat the whole family. We are called family medicine physicians because our patients are part of our extended family.

Being a rural family physician is incredibly rewarding, but in the last several years, it has gotten much more difficult. My patients have more chronic medical problems that require complex, ongoing care management. More and more they are looking to our practice to help with their depression and anxiety, meeting basic needs, and navigating an increasingly complex health care system.

But instead of providing primary care practices with support to meet these growing patient needs, we are left struggling to stay afloat as payments shrink and

administrative requirements multiply.

Our failure to invest in primary care is being felt across the country in patient outcomes and repeated challenges trying to find a primary care physician. Data released just this week shows that over 16,000 primary care physicians have left the workforce over the past year.

But as a country we have never needed primary care more than we do today. Despite much higher spending per person, the U.S. spends less on primary care, has the highest rates of people with chronic conditions, the lowest life expectancy, and highest preventable death rates compared to our peer countries.

Primary care leads to better population health, more equitable outcomes, and lower mortality rates. In other words, primary care is uniquely suited to help address the pressing health care problems we face today.

I am pleased to see the subcommittee's attention on ways to better support patients and physicians with appropriate payment for the comprehensive patient-centered work we do and a tangible reduction in administrative workload.

We are encouraged by steps Medicare has taken to more appropriately value physician office visits. In 2024, CMS has proposed another incremental step to better value primary care. The G2211 add-on code would better account for the time, resources, and expertise involved with providing comprehensive primary care.

Primary care office visits are more complex, and G2211 is intended to recognize that. Opportunities to meaningfully invest in primary care under our current system are rare, but this is one of the few of them that we can use.

I urge Congress to support implementation of this code.

However, coding and billing challenges alone will not fix the broken physician Medicare payment system. We need congressional action. I strongly urge Congress to reform budget neutrality requirements. Enact an annual inflationary update for physician payments. Support physician practices moving into value-based payment models, and pass the Lower Cost More Transparency Act.

But strengthening Medicare for patients goes beyond just improving payment. Congress must address

administrative burden which has become totally unmanageable. My staff and I spend hours every day navigating prior authorization and step therapy requirements that prevent patients from being able to access evidence-based treatment in a timely manner.

Thankfully, the subcommittee has the opportunity to address some of these issues by first passing the Improving Seniors Timely Access to Care Act. Reforming step therapy in Medicare and Medicaid, requiring Medicare Part B coverage of all recommended vaccines so that we can give all vaccines in our office and not have to go to the pharmacy for that.

Standardizing quality measures across payers and programs.

Primary care in this country is at a tipping point, but Congress can help to change that. Improving payment and reducing administrative burden will not only be an investment in primary care, but also in our patients and your constituents.

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

[The prepared statement of Dr. Furr follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony.

Dr. Patt, you are recognized for five minutes for your testimony.

I think you are going to have to hit the mike button.

STATEMENT OF DEBRA PATT, M.D., Ph.D., MBA

*Dr. Patt. Chairman Bucshon, Ranking Member Eshoo, and members of the Health Subcommittee, I appreciate the opportunity to testify on this extremely important hearing on the prognosis of medical care in America.

My name is Dr. Debra Patt, and I have spent the past 17 years seeing and treating breast cancer patients in Austin, Texas at Texas Oncology, a large physician-owned private practice in the great State of Texas.

I also serve as an Executive Vice President of Texas Oncology and a Vice President and board member of the Community Oncology Alliance.

As you consider policies in today's hearing, I want you to envision the consequences of inaction. Continued Medicare fee schedule payment cuts pose real and serious threats to Medicare beneficiaries accessing medical care.

Decreasing reimbursement causes a chain reaction that results in provider network inadequacies, decreased access to care, inability to manage staffing shortages, and decreased quality of care for Medicare beneficiaries.

The disproportionate burden felt by non-hospital affiliated practices like mine, the disparity in reimbursement is fueling consolidation into hospital systems that are driving up the cost of medical care for all Americans.

We face continued cuts in Medicare reimbursements. Since 2014, medical inflation has increased substantially every year, yet Medicare reimbursements as measured by the conversion factor have only decreased.

The ever widening gap between the inflation rate and Medicare payment can be seen in the graph included in my written testimony. It shows medical inflation has risen by 28.4 percent, while the conversion factor has had a 5.4 percent decrease since 2014.

We have issues of network adequacy, quality of care, and physician burnout. CMS is constantly cutting Medicare reimbursement for physicians. It has the natural consequences that harm Medicare beneficiaries as it results in decreased access to care through network inadequacies.

I frequently have breast cancer patients in my clinic that I have to juggle and ask favors to get them to be seen

by a primary care physician or another subspecialist. So I have to use my time. I have to refill their primary care medications, and they frequently have gaps in care where no one is refilling their medications and they go without their diabetes or their hypertension medications.

This causes care fragmentations, delays, and detours in appropriate care.

The pressures on independent physicians today is leading to increased physician burnout. According to a recent study, over 145,000 health care practitioners left the health care industry from 2020 through 2021, threatening access to medical care. Seventy-one thousand of these were physicians. This is alarming.

We face staffing shortages. This burden of declining reimbursement has been exacerbated by a national crisis in shortages in health care staffing. Just last week you might have seen the announcement by Kaiser Permanente that after a three-day strike, they reached a negotiated deal to increase payments by 21 percent over five years.

As a physician in private practice facing decreased cuts only challenged further by inflation, how would I pay

for increases in staffing to continue to staff my clinics and be competitive?

The natural consequence of this is breast cancer patients are not able to get mammography. Cancer infusion centers and radiation facilities are not able to open to capacity because we have staffing shortages.

We are on the verge of a major crisis in medical care, and we at best are just fiddling as Rome burns. Inaction will lead to further consolidation and increased health care cost.

Independent physician reimbursement cuts adversely impact the entire health care ecosystem. However, because hospital systems receive an annual Medicare inflation adjustment, the physicians in private practice do not, and the ever widening gap between independent physicians and hospital reimbursement is contributing to consolidation of medical care into the more expensive hospital settings.

This is especially true with 340[b] hospitals. A study of the top 340[b] hospitals showed that some markup cancer drugs are unbelievable at five times, meaning if you have a cancer drug that costs the hospital $5,000, it can be marked

up to $25,000.

In addition, by ignoring hospital survey data, CMS is overpaying 340[b] hospitals by close to 50 percent, contributing to a six percent premium increase for Medicare beneficiaries that they will pay in 2024.

We need to pass meaningful legislation. I want to underscore that it is critical at this time for Congress to fix the looming Medicare payment cut, as well as provide independent physicians with the much needed medical inflation update.

Congress needs to make payments equitable in the hospital and private practice settings by passing site neutrality legislation and fixes to a broken 340[b] payment system.

Additionally, Congress needs to address abuses by insurers and their PBMs, including excessive prior authorizations that hinder quality and timely cancer care.

As a doctor in private practice, we need you to consider this legislation and make meaningful change to improve the prognosis of medical care for Americans in action will fuel the chain reaction resulting in burnout,

shortages, network inadequacy, and a fragmented and disrupted medical care for Medicare beneficiaries.

We need you to act now to improve the prognosis of the American health care system.

Thank you for your time, and I am happy to take any questions.

[The prepared statement of Dr. Patt follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony.

Mr. Albanese, did I pronounce that correctly?

*Mr. Albanese. Yes. Thank you.

*Mr. Bucshon. You are recognized for five minutes for your testimony.

STATEMENT OF JOE ALBANESE

*Mr. Albanese. Vice Chair Bucshon, Ranking Member Eshoo, and members of the subcommittee, my name is Joe Albanese, and I am a Senior Policy Analyst at Paragon Health Institute, a think tank dedicated to empowering patients and reforming government programs.

I want to thank you for inviting me here today to discuss how to improve payment policy in Medicare. My testimony today reflects my own views.

Medicare payment policy should reflect three key goals: first, maintaining access to care; second, minimizing cost; and, third, improving payment accuracy.

We should all be committed to securing seniors' access to health care. Fortunately, 98 percent of physicians accept Medicare rates, and this percentage has increased over time.

However, policies that increase administrative burden or underestimate physician pay could undermine this.

Congress must also be cognizant of the fact that Medicare is on an unsustainable trajectory and should reduce

long-term cost growth.

These costs fall directly onto the shoulders of beneficiaries through cost sharing and premiums. Just last week CMS announced that Part B premiums will increase by roughly six percent next year due to rising Medicare spending. On average, seniors already spend about 28 percent of their Social Security checks on expenses in Parts B and D alone.

The fiscal sustainability of Medicare itself is also crucial. Part B, which covers physician services, is the fastest growing part of Medicare. The Medicare Trustees project that this Trust Fund, which is mostly financed by general revenues, will consume over one-fifth of Federal income tax revenue by the end of the decade.

Rising costs will directly contribute to deficits, which may result in painful benefit cuts, tax increases, or economic harm to families in the future.

Finally, Medicare payment policy directly distorts decisions in the health care sector. Fee-for-service payment encourages a higher volume of health care procedures regardless of their quality.

Administrative price setting by government agencies is limited by data availability and bureaucratic decision making processes, which do not reflect the true value of a service.

Both Congress and CMS have historically struggled balancing these three goals with Medicare payment policies. Under MACRA and the sustainable growth rate before that, the per unit price of physician services stagnated, which helped to control overall spending. However, the volume and intensity of such services on a per enrollee basis rose, and Part B spending still grew in other areas.

Furthermore, maintaining lower payment rates may compromise long-term participation by doctors. So far data from CMS and MedPAC have found that access to physician services is stable or improving.

However, Congress could enact policies that would improve Medicare payment policy on these dimensions for both beneficiaries and taxpayers.

First, Congress should offset any physician payment increases with other Part B savings. Spending on out-patient hospital services, Part B drugs, and other areas has

grown rapidly. Commonsense policies like site neutral payments or reducing statutory overpayments on drugs can save hundreds of billions of dollars without making any changes to seniors' benefits.

Second, Congress should adopt more market-based pricing for doctors. The current process leads to observable errors in payment rates for certain services and disparities between specialties have reduced the supply of primary care practitioners.

Simply increasing pay by inflation will not address these issues. Market competition is a more efficient way to determine the economic value of a service. So gradual improvement is possible by tying Medicare payment policy to rates negotiated by Medicare Advantage plans.

Third, Congress should eliminate quality payments programs like MIPS and the financial incentives for advanced APM participation. These policies have been the clearest failure of MACRA and have been responsible for increasing clinician burden without improving value.

A recent CBO report has reaffirmed that APMs have lost money for Medicare instead of saving money.

Government experimentation and micromanagement in health care delivery is not a path to success, and it does not make sense to subsidize participation in models that do not work.

Ultimately quality metrics are best when they enable seniors to make informed choices between coverage and care options. This is already possible in Medicare Advantage, which has become increasingly popular in recent years. Policy makers should ensure that it remains a viable option for seniors and encourage participation between MA and fee for service.

Balancing policy goals is a difficult task, but removing government distortions rather than adding new ones would be a much more effective way of maintaining access to care, containing costs, and improving payment accuracy.

Thank you, and I look forward to answering your questions.

[The prepared statement of Mr. Albanese follows:]

**********COMMITTEE INSERT**********

*Mr. Bucshon. Thank you for your testimony.

I now recognize Dr. Fiedler for five minutes for your testimony.

STATEMENT OF MATTHEW FIEDLER, Ph.D.

*Dr. Fiedler. Vice Chair Bucshon, Ranking Member Eshoo, and members of the subcommittee, my name is Matthew Fiedler, and I am a health economist and a Senior Fellow at the Brookings Institution.

I am grateful for the chance to appear before you today to discuss ways to improve how Medicare pays physicians.

I want to begin by discussing the tradeoffs involved in deciding how much Medicare is paying physicians. Broadly, policy must balance two objectives. The first is ensuring that Medicare beneficiaries can access high quality physician care.

The second is limiting the cost that higher payment rates impose on taxpayers, who bear higher program costs, on beneficiaries, who bear Medicare premiums and cost sharing, and even on the privately ensured who research finds pay more for physician care when Medicare pays more.

Data on how well Medicare beneficiaries are able to access physician care can help guide policy makers as they work to balance access and cost. In that vein, I want to

highlight two facts.

First, survey data show that most Medicare beneficiaries do not currently report major problems accessing physician care. In 2022, around four-fifths of beneficiaries who searched for a new primary care provider said they either had no problem or only a small problem finding one.

About nine in ten who sought a new specialist said the same thing.

Similarly, about two-thirds of beneficiaries who sought care for an illness or injury reported never waiting longer than they wanted to to get an appointment, and more than half said the same for routine care.

And along all of these dimensions, Medicare beneficiaries report comparable or slightly better access to physician care than the privately insured.

Second, Medicare beneficiaries' access to physician care has remained relatively stable even over a two-decade period in which practice's input costs have grown faster than Medicare's physician payment rate.

This could indicate the changes in Medicare payments

currently only have a modest effect on access or, alternatively, that other changes in the delivery system, like greater reliance on non-physician professionals, are offsetting slow growth in physician payment rate.

Looking ahead, it is possible that the delivery system might respond differently to future payment changes than it did to past ones. Perhaps especially if input costs outpace payments rates indefinitely.

Additionally, under current law input costs will likely outpace payment rates by more during the next year or two than they did during the typical year in the past two decades.

The data I am speaking to here also do not address transient outcomes other than access like quality.

Nevertheless, this recent history does suggest that there is some scope for Medicare's physician payment rates to grow more slowly than input costs in the years to come without a decline in access.

In the time I have left, I want to briefly highlight four structural changes to how Medicare pays physicians that are worth considering regardless of what policy makers

decide about the level of payment.

The first is eliminating the merit-based incentive payment system, or MIPS, which evidence suggests is failing at its goal of improving the quality and efficiency of patient care but is creating large compliance costs for clinicians.

Since eliminating MIPS would make it cheaper for clinicians to treat Medicare beneficiaries, it could be a low-cost way of addressing concerns that Medicare's physician payment rates are inadequate.

The second is maintaining bonuses for participation in advanced alternative payment models, or APMs, rather than allowing these bonuses to decline sharply as scheduled under current law. In contrast to MIPS, well designed APMs do appear to improve the efficiency of patient care, and the current payment bonus both encourages these models' uptake and gives CMS flexibility to improve their design.

The third is insulating future physician payment rates from inflation shock but in a budget neutral way. Physician payment updates are currently fixed in law. So shocks to economy-wide inflation can cause inflation adjusted payment

rates to be higher or lower than currently expected.

This could be avoided without a large scored cost by specifying the payment updates should equal the Medicare economic index minus an appropriate fixed percentage.

The fourth, which takes me beyond physician payment per se, is adopting site neutral payment for ambulatory services, as this subcommittee has considered at other points this year.

The benefits of site neutral payment in terms of reducing cost to the Medicare Program and beneficiaries and removing incentives for consolidation are likely familiar. So I will not repeat them.

But I will note that site of service payment differences will likely grow over time if Medicare's physician payment rates continue to grow slowly in the years to come, which will magnify the importance of shifting to site neutral payments.

Thank you, again, for the opportunity to testify. I look forward to your questions.

[The prepared statement of Dr. Fiedler follows:]

This is an unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker.

1800 **********COMMITTEE INSERT**********

1801

*Mr. Bucshon. Thank you very much.

That concludes the testimony. We will now move into members' questions.

I will recognize myself for five minutes.

I want you to clarify something really quickly, Dr. Fiedler. You said four-fifth of people, Medicare patients, do not have trouble finding a new primary care physician. That means a fifth of them do.

You presented that as kind of that was a positive number. From my perspective, it is awful. A fifth of Medicare patients when they lose their primary care doctor or their doctors retire are struggling to find a new physicians. Is that what you said?

*Dr. Fiedler. So that is correct, yes, and so I think, you know, the question is relative to what, and that is a far better number actually than we observe in private insurance.

And then there is, I think, a separate question of to what extent would increase in payments actually address that problem.

*Mr. Bucshon. Yes. So the reality is then it is the

chicken or the egg, right? Because we have a shortage of primary care physicians because of reimbursement challenges. So I think we can agree to disagree, but it is the chicken or the egg, right?

You do not pay doctors enough. They do not go to rural America. People cannot find a doctor.

*Dr. Fiedler. I mean, I think one _

*Mr. Bucshon. You are saying that payment does not matter, but I am saying that that is the root cause of the problem.

*Dr. Fiedler. Right, and I think it is possible that payment matters to some degree. In particular, I think we do observe that those access measures are somewhat better for specialty care than primary care, and so that might be consistent with the view that payment does matter at the margins.

I think what is true is given that we have seen a large decline in payments without a large deterioration in access. The question is how much does it matter for that.

*Mr. Bucshon. Yes. I know you are an economist, but the economists need to take a tour through rural Southern

Indiana and maybe it might change your view.

Also you said something about specialists. Two-thirds of seniors, and then the last number was just over 50 percent of seniors. Can you clarify those because, again, those are awful numbers. You said they were positive, but they seem pretty negative.

*Dr. Fiedler. So this is the number of people, two-thirds is the number of people who reported never waiting longer than they wanted to for an appointment.

*Mr. Bucshon. Okay. So a third do.

*Dr. Fiedler. But many of those people are actually responding that they only sometimes or occasionally.

*Mr. Bucshon. Okay. Fair enough.

*Dr. Fiedler. So I mean there is a tradeoff between how much can you improve access for a given amount of additional _

*Mr. Bucshon. Yes, yes, fair enough. Dr. Patt, I understand you run your own practice, and due to a variety of factors, many medical specialties are facing cuts of up to ten percent this year potentially.

As an independent physician, can you share what an

eight or ten percent cut would mean to your ability to operate a physician practice and what that might mean to access for patients?

In your testimony, you talked about that briefly, but can you clarify that even more?

*Dr. Patt. Yes, sir. So when we have decreases in reimbursement, you know, that has a trickledown effect to everyone that we employ.

So in Texas Oncology, in my organization, we employ about 6,000 employees, and it is important for us to give appropriate compensation increases to stay competitive. Otherwise others that have greater funding resources will take them away and we are not able to keep appropriate staffing.

So the natural consequence of a cut is that we are not able to pay our staff appropriately at a competitive rate to stay staffed appropriately.

*Mr. Bucshon. Yes. You also talked about the pressure that independent practices feel to sell to health systems. In fact, my medical practice, we sold to the hospital in 2005. We got to the point where we could not sustain an

independent cardiology-cardiac surgery practice, and that was almost 20 years ago. It is worse today.

In that context of physician payment, site neutral payments and other things, I have had conversations with hospitals and health systems that do not really feel like that this has had an impact on the physician's ability to stay independent and also has not been a major factor in consolidation.

Can you talk about how that dynamic, the difference in payment, the payment disparity has an impact on consolidation and physicians having a hard time staying independent?

*Dr. Patt. Absolutely. So thank you for the opportunity to answer the question.

It is a very clear correlation. If our reimbursement is less, we cannot pay staff as much. You know, we are in a competitive environment of staffing. Nurses, there is a nursing shortage throughout the country. If the competing hospital is able to pay them a large signing bonus and increase their compensation, they take away our staff and we are not able to stay open. Then we operate less

efficiently.

And then, you know, if you are not able to stay financially viable, there is always an attractive offer to sell your practice to the hospital system, and that is how consolidation occurs. At some point it becomes more financially viable to transition.

And really it is not a closure of the practice. It is more just changing the shingle and all the insurance contracts to double. So that consolidation is a natural increase in the cost of care.

It is not in America's best interest to see that happen.

*Mr. Bucshon. Thank you very much.

My time has expired.

I now recognize the ranking member, Ms. Eshoo, for five minutes.

*Ms. Eshoo. Thank you, my friend, Dr. Bucshon.

I listened very carefully to your comments to Mr. Fiedler. Mr. Fiedler, it seems to me that _ and I might be wrong _ but my takeaway from some of the things that you said was that you are not taking into consideration the

impacts and they are lasting from COVID.

I mean, article after article after article after editorial speaks of physicians in our country that have just left their practice, just left their practice.

We have heard at different forums testimony here of professions being hollowed out, and then explore what we can do to bring in a whole new wave of professionals.

So you do not make mention of that. You say, well, two-thirds, one-third. Sounds rosy, but I agree with Dr. Bucshon. I mean, there is something missing in this in what you said.

So I do not know when you put those numbers together and that they are all rosy. I do not think so, and I am a real commonsense person. All of us here have heard the testimony from professionals. We know what is going on in our own communities. We are not making this up.

So maybe you can go back and take a look at it and come back and give us something else to take a look at.

We have heard a lot today about improving patient access to care. CMS released data from a survey showing 92 and a half percent of Medicare beneficiaries reporting no

trouble accessing care.

Well, I do not know where they got this from, but you would get a different answer in my district.

Dr. Furr and Dr. Patt, you are both doctors. In your experience, tell us, you know, for the record how doctors are reacting to the decreasing Medicare reimbursement.

Are more doctors retiring, turning away from Medicare patients?

We really need to get this on the record here. It is not that I am asking you questions that I think I know the answer to, but I want this on the record, and, Mr. Fiedler, while most Medicare beneficiaries report they are able to see their doctors, I do not know when this survey or whatever was taken.

When was it? How current is it?

*Dr. Fiedler. So the data I am speaking to are from 2022.

*Ms. Eshoo. Well, that is almost two years old.

At any rate, how do geographical differences come into this? How do they play into it? Is there that much of an effect as a result of them?

And how does reimbursement play a role in addressing the access issue?

So you can split up the time, a minute and 36 seconds.

*Dr. Furr. So the geographical floor is very important. If that floor is lowered and is taken away, and for rural physicians in particular in the survey areas, when you are in a rural area, not only are you in a rural area usually taking care of more low-income patients and disadvantaged patients, so you do not have the payer mix that balances that out.

*Ms. Eshoo. How often are those geographical designations reviewed?

I remember many years ago, I mean, I got into such a protracted battle because I had to, because one of the counties in my congressional district bore the designation of being rural, except that was when Medicare was established. It had earned that rural designation in 1966, and we were losing doctor after doctor after doctor. It was pennies on the dollar.

So how often is that reviewed?

*Dr. Furr. I am not sure how often it is reviewed, but

I do know the floor is going to go away at the end of this year. So it is critically important that Congress act and keep that floor from going away.

I can tell you from practicing in a rural area, it is not cheaper to live in a rural area, and particularly after COVID. Gas is not cheaper in a rural area. Hiring employees is not cheaper.

I have got a number of my patients who are now travel nurses. I cannot afford to have them because they are getting the money that is being paid in Cape Cod and other areas.

So it is not cheaper. So that is why we need to have that floor and not let it go away.

*Ms. Eshoo. Mr. Chairman, my time has expired.

Dr. Furr, I will send you my questions in writing, and you can respond in that manner.

And thank you to each one of you for being here today. I know our schedule has been rocky and not all that predictable, but thank you for being here this afternoon.

And I yield back, Mr. Chairman.

*Mr. Bucshon. The gentlelady yields back.

I now recognize Mr. Bilirakis for five minutes.

*Mr. Bilirakis. Thank you, Doctor. I appreciate it very much.

I want to thank the panel for their patience.

I am glad we can discuss proposals that look to minimize disruptions to care for our seniors and provide stability for Medicare providers. I am particularly glad we have prioritized preventing additional consolidation in the health care sector so far this Congress.

And I am pleased my bill, the Providing Relief and Stability for Medicare Patients Act, was noticed for today's hearing.

My bill, H.R. 3674, which I lead with Representative Cardenas, aims to prevent office-based specialty cuts that were adversely affected by the clinical labor pricing update within the Medicare physician fee schedule.

I believe these cuts, some upwards of 25 percent, have only fueled further closures of these community providers and worsened consolidation that ultimately hurt patient access as they end up in more expensive settings. And I see this all over my district.

I want to submit a letter for the record from a coalition of providers in support of my legislation that will provide some relief and also submit a statement for the record from the Society for Vascular Surgery discussing its support for H.R. 3674 and the need to avoid disruptions in care for Medicare beneficiaries.

I ask for unanimous consent that both be inserted into the record, Mr. Chairman.

*Mr. Bucshon. Without objection.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bilirakis. Thank you.

And my question is for Dr. Patt.

Thank you for your testimony on behalf of the oncology community. We appreciate it, sir.

You know the importance first hand about maintaining community-based settings for patients. Can you tell us what the impact on office-based providers would be if we do not work to alleviate these cumulative, year-over-year cuts in the physician fee schedule?

And can you tell me what impact it would have on patient access please?

Thank you.

*Dr. Patt. Thank you, Congressman, for the question.

I think that will have many implications if the cuts are not alleviated. I think the natural consequence is that private groups that are in community practice will not stay viable and not able to have competitive staffing resources. When that happens, we have to close treatment times and not be open to most of our capacity, and that decreases access and also furthers consolidation.

So I think efforts to, you know, move reimbursement in

your legislation _ thank you for leading it _ would go a long way to improve that and make community practice more sustainable.

I also think that aside from those individual changes, that the site of service disparity poses a continued challenge to the threat of consolidation, and when you have consolidation happen, you are going to have access to care issues for Medicare beneficiaries and all Americans.

*Mr. Bilirakis. And I see that, and I know the patients in my district prefer the commute to care for a lot of reasons.

Beyond my bill, I also want to thank the chair for putting up legislation I co-lead with Representative Hudson and many of the bipartisan members of this committee, the Saving Access to Laboratory Services, H.R. 2377, which will provide the much needed permanent solution to clinical laboratory reimbursement in Medicare. I know the chairman here is a leader in that.

We must prevent these PAMA cuts from happening while prioritizing long-term statistical sampling changes that protect public health and innovation.

Lastly, I wanted to quickly thank the chair again for including the EMPOWER Act, H.R. 4878 to help the physical therapy workforce in this case, and I hope that we can go further in a future hearing by discussing my bipartisan bill, H.R. 1617, the Prevent Interruptions in Physical Therapy Act, as well.

I look forward to working with the chairman and the committee on this important legislation, and I hope it is considered soon. Physical therapy is so very important, particularly for our Medicare patients.

So thank you very much, Mr. Chairman. I yield back.

*Mr. Bucshon. The gentleman yields back.

I now recognize Dr. Ruiz for his five minutes.

*Mr. Ruiz. Thank you, Mr. Chairman.

Medicare is our Nation's promise to seniors. The establishment of the Medicare Program was intended to ensure that seniors have affordable access to the health care they need when they need it and when they need it most, in their elderly years.

And Medicare needs work. Seniors should not have to wait to receive necessary medical services, and they should

not be turned away by doctors simply because they are covered by Medicare.

The fact that we are having this hearing today is a testament to the reality that the system is broken, and we need to take action to protect the patients and medical professionals participating in the Medicare Program. We need to protect and strengthen Medicare for our seniors.

So we need to address a major barrier to care for patients, which is the physician reimbursement rates, the Medicare participation for the physicians charged with providing these cares.

For years physicians have been experiencing cuts to their Medicare reimbursements, year after year, even while other Medicare providers have experienced increases for inflation.

You see from 2001 to 2023, inflation adjusted payments for physicians declined, declined by 26 percent even amid the rising cost of running a medical practice. So you see this widening gap.

On top of that, physicians received a two percent across the board cut to their Medicare conversion factor in

2023, and this is after the burnout and the experience that they had during the pandemic.

And physicians are facing another potential 3.36 percent cut in 2024. Why does this matter? And all of you have said this eloquently.

We have a physician shortage crisis already in our country, most pronounced in rural, underserved areas. When you on top of that inhibit the ability for a physician to provide care to their patients and not meet their bottom line, they are going to practice elsewhere where they are going to get higher reimbursement rates or they are going to choose the insurances that are going to reimburse them the most, and they will drop Medicare, and that will leave our patients without a physician for them.

This is about patients, not physicians. This is about putting patients first and ensuring that they have the doctors and the medical professionals able to take care of them and keep their doors open, especially in underserved areas.

So the physician fee schedule is broken, and we cannot afford for doctors to close their doors or take fewer

Medicare patients because they cannot afford to treat them. Tying Medicare reimbursement rates to rising inflation will go a long ways towards protecting physicians and ensuring reliable access to care for patients.

And that is why my bipartisan bill with Dr. Bucshon and Dr. Miller-Meeks _ Dr. Bucshon was here earlier, but Miller-Meeks is still here _ the H.R. 2474, Strengthening Medicare for Patients and Providers Act, will adjust Medicare physician reimbursement rates based on inflation by tying reimbursements to the Medicare economic index.

So considering the trending decline in physician's payments rate, Dr. Fiedler, how do you foresee this impact to patient access and quality of care in the future?

*Dr. Fiedler. So as the saying goes, predictions are hard, especially about the future. I do think one of the striking features of the last two decades is that patient access in Medicare has been remarkably stable even during a period where physician payments rates have lagged behind input costs.

*Mr. Ruiz. And that is a testament to the physicians who care about their patients and will practice and take

care of them and treat the patient first and foremost. So I appreciate that.

But there are some challenges for them to do that, and since we have limited time, I will ask you to answer that with my office in writing if you can.

*Dr. Fiedler. I would be happy to.

*Mr. Ruiz. Because there is another bill that I am a co-sponsor of, and I want to send the strong message to our chairman to please have a hearing on this bill and to please pass it through committee.

I know that Ranking Member Anna Eshoo is in support of this as well, and I think we can pass a good bipartisan bill immediately to address this issue.

But the H.R. 5526, the Seniors' Access to Critical Medications Act of 2023, which I am a co-sponsor, will allow physicians to help mail their medications to their patients. We have a lot of patients with mobility transportation issues. This will help strengthen Medicare by enabling seniors to receive their medication without the onerous barriers that it takes for them personally to go and get the medications themselves.

And with that I know I ran over my time. I thank you for your grace, and I yield back.

*Mr. Guthrie. [Presiding.] The gentleman yields back.

The chair now recognizes Dr. Burgess for five minutes for questions.

*Mr. Burgess. And I thank the chair.

I do want to thank our witnesses for being here and for your forbearance in what has been sort of a disjointed day.

Dr. Furr, I do not know if you were here earlier in the hearing. I talked about one of the bills that is the subject of this legislative hearing, the Provider Reimbursement Stability Act of 2023.

Current Medicare fee schedule as we have heard over and over again is unsustainable and unpredictable. This is due in large measure to what is known as budget neutrality. The mechanism often leads to across-the-board cuts and make it harder for practices to survive.

So with what you have heard about that this morning, can you speak to how provisions in that legislation would stabilize and promote accuracy within the physician fee schedule?

*Dr. Furr. Yes. We need to get where the physicians are not going against each other, and that is what budget neutrality does. So I think we definitely need to have that conversation because that definitely needs to change.

I think part of what you have got in there changing the cap or where that changes is incredibly important, and I think it would go a long way.

*Mr. Burgess. So that threshold has not changed since 1992, and the adjustment for constant dollars and the Medicare spend currently would result in a significant increase in that threshold, and that you feel would be beneficial to the practicing physician?

*Dr. Furr. Yes, sir.

*Mr. Burgess. So, Dr. Patt, I cannot thank you enough for being here. I know you had to ride the train late last night, and it was a lot for you to get here, and we really do appreciate that.

In your written testimony, you mention examples of how consolidations lead to rising health care costs. Right now I am working on a discussion draft that would allow for physician-owned hospitals that are 35 miles from an existing

hospital or critical access hospital to open or expand.

I would like to remind everyone this is a draft, and I am working on a few technical changes, but let me just ask you the general question. Do you think physician ownership could be beneficial where health care is limited?

*Dr. Patt. I do. I would be very supportive of that idea.

*Mr. Burgess. A very succinct answer.

Dr. Furr, let me ask you the same question.

*Dr. Furr. You know, physicians, most family physicians cannot afford to run a hospital, but if they can afford it and own it, I have no problems with that.

*Mr. Burgess. But who better to establish a facility in a rural area or an underserved area than someone who actually knows what a hospital is supposed to be and a well-run hospital looks like, and the fact that we are precluded from that activity by virtue of our professional degree.

People on this committee have heard me say it over and over again. It is wrong that a hospital can own a physician and a physician cannot own a hospital. It makes no sense. In a free country, it should not be that way.

I do know that there are concerns on both sides of the dais, but I would just say, Mr. Chairman, before I yield back, I think this solution allows physicians to maintain activity in the business of health care while providing patients access to the care they need and will allow doctors to continue to be able to afford to stay in practice when they have so many things working against them.

In the interest of time, I will yield back.

*Mr. Guthrie. The gentleman yields back.

The chair will now recognize Mr. Cardenas for five minutes for questions.

*Mr. Cardenas. Thank you very much, Mr. Chairman and Ranking Member, for holding this very important hearing.

I agree somewhat with some of the comments my colleague just made. It seems like in this country you can be a lawyer and own the practice, the law firm, but if you're a doctor, you cannot own a hospital. Gosh, it sounds like we trust lawyers more than doctors in this country.

But anyway, hopefully we can get to some good policy on that. I really appreciate that.

This Congress I am proud to co-lead the Providing

Relief and Stability for Medicare Patients Act of 2023, along with my Energy and Commerce Committee colleague _ get this _ Republican Bilirakis. Yes, I am a Democrat and he is a Republican, and we are co-leading on that bill as well as Representatives Murphy and Davis.

This bill would mitigate significant cuts to office-based specialists by increasing non-facility practice expense relative to value units, or RVUs, for procedures performed in office-based settings that utilize high tech medical devices and equipment.

I believe this is important to ensuring that we preserve access to office-based care settings, many of which face a very real possibility of closure or consolidation. Analysis by Health Management Associates have found that office-based specialists, including cardiologists, radiation oncologists, vascular surgeons, and radiologists have been subject to cumulative cuts under the physician fee schedule since 2006.

This is simply not sustainable, and I worry that patient care will suffer because of it.

Our focus should be on building robust systems that

ensure our communities can access the care they need.

I just spoke to an oncologist who owns a small practice, and he was mentioning how difficult it is, but I interrupted him. I said, "Okay. If your practice were to close, how far would your patients have to go to be able to get your service?''

He said, "Sixty miles in one direction, 95 miles in the other direction.''

That is rural America, and I say that because I care about access for all Americas. I represent part of Los Angeles. You can go a mile or two in any direction and you are going to find doctors. You can go a few more miles and you are going to find oncologists, et cetera.

So I just want to point out that please do not think that if we represent a big city we do not care about rural America, and as well, I do not think that my colleagues who represent rural America do not care about people in big cities either.

I just wanted to point that out.

I have a question for Dr. Patt, Debra Patt.

Dr. Patt, in your testimony, you note that decreasing

reimbursement causes a chain reaction that results in provider network inadequacy, decreased access to care, in ability to manage staffing shortages, and decreased quality of care for American seniors and other Medicare beneficiaries.

What is the impact of these sustained clinical labor cuts, especially in underserved communities?

*Dr. Patt. Thank you for the question.

I think that these cuts will result in doctors not being able to staff appropriately, which overburdens the doctor and makes doctors exit the workforce. I think we have observed this.

Then when practices are subject to close, there is frequently consolidation of medical care. The natural consequence of that is that it drives up health care costs.

So I think that there is a number of factors that all influence access to care and the cost of care at the end of the day that will be harmed by not making change today.

*Mr. Burgess. Yes, thank you.

It is important that we focus also on health care workforce so that we can get an adequate environment out

there.

A physicians survey in my home State of California found that 87 percent of physicians expressed that low Medicare reimbursement and high cost to practice in California are negatively impacting physician recruitment and retainment, and I am sure that is not just for California. That is for the rest of the country, too.

Congress must work collaboratively to ensure that the physician workforce is equipped to address the needs of communities they serve, especially if we want to ensure that our health care workforce is as diverse as the community that they serve.

A question for Dr. Fiedler.

In your testimony, you mentioned evidence suggests that reductions in Medicare physician payment's rates potentially affects who enters the medical profession.

Can you expand on this?

And what do you expect that the impact would be on workforce diversity?

*Dr. Fiedler. There is some evidence that, and particularly regarding specialty choice, but it likely also

affects [audio malfunction].

The question then is how large those effects are and how to balance the resulting increase in supply of physician services from higher payment rates against the cost that those higher costs impose on taxpayers, on beneficiaries, and potentially on people with private insurance.

*Mr. Burgess. Wow, it sounds like we need a better efficient system.

Thank you very much. I have just run out of time.

I yield back.

*Mr. Guthrie. The gentleman yields back.

The chair now recognizes Mr. Carter from Georgia for five minutes.

*Mr. Carter. Thank you, Mr. Chairman.

And thank all of you for being here.

As we all know, we have got a health care worker shortage here in America, and we certainly have it in the State of Georgia as well.

As a consultant pharmacist in nursing homes for many years, nursing homes have been especially impacted by the health care shortage, and it is something that I am very

concerned about.

Health care provider shortage is one of the biggest challenges facing our health care system and our Nation right now. We all know that.

In fact, there was a recent survey that said that the U.S. will face a shortage of up to 139,000 physicians and advanced practitioners by 2033, including shortfalls in both primary and specialty care.

You know, I do not know that it is the total reason, but I would submit to you that more than any other agency, that the FTC has failed the American public by allowing consolidation in healthcare like they have.

I would submit to you, as a pharmacist, that the primary reason for high drug costs is the consolidation, the vertical integration that exists in the drug pricing chain with the insurance company, also the PBM, that owns the group purchasing organization, that owns the pharmacy, that owns the doctor.

Dr. Furr, do you know who employs the most physicians in America right now?

*Dr. Furr. I'm not for sure, but I would guess United

Health Care or _

*Mr. Carter. You are absolutely, 100 percent correct. United Health Care employs more physicians in America now than any other organization.

And it is not just pharmacy. It is also in the healthcare system. It is the hospitals. Now, look, folks, I am not opposed to anybody making money. I know we live in a capitalistic society. I get it and I understand all that.

We had a meeting, Mr. Chairman, here with the Energy and Commerce Committee. It wasn't a hearing; it was a meeting. We had the Congressional Budget Office, the CBO, we had the director and we had 20 staff members. I asked them that question. I said, give me one example of where consolidation in healthcare has saved money. Crickets. Nothing.

One example where consolidation in healthcare saved money. Whether you're a Democrat, a Republican, or an Independent you wall want the same thing in healthcare. You want accessibility, affordability, and quality.

And consolidation has done away with all of those, I would submit to you. Now, I'm not saying we don't have

quality healthcare. We do. We've got the best healthcare in America, in the world, right here in America, but the consolidation that has gone on.

You know, and I don't expect for you to tell me, but I'm going to tell you who I am voting for for President and that is going to be Teddy Roosevelt, because we need somebody back here who will bust it up and he can do a better job dead than most of these people can alive.

I am just telling you.

Let me ask you, Dr. Furr, what kind of misaligned incentives do you think that we have right now in healthcare that is causing some of these shortages?

*Dr. Furr. I think some of the new things and the things that, when you talk to our physicians, our biggest thing is administrative burden. And as you know, working as a pharmacist, when an administrative burden started out, that was a take care, high-cost items, so we weren't going to overusing PET scans and our mobility devices. And now we're doing preauthorization for generic drugs so that, just because they changed their formulary, a patient that I've had on their diabetic hypertension medicine for years, is

well controlled, I get a letter from the program, from their plan, saying we're no longer going to cover that drug.

And then they won't even tell me what drug they will cover. So then I've got to call the pharmacist and say, what drug do they cover? They say, we don't know. You've got to send it in and then we'll let you know if it goes through.

So you might have to do that two or three times. There's no transparency there. At least give me a half a shot by telling me what you're going to cover. And they might be doing it to save two or three cents on the dollar.

And then, for what little savings they get, that patient might wind up in the Emergency Room. That patient might have to make two or three visits while I'm changing their medicine to get them back under control.

*Mr. Carter. And not only that, and I will tell you, when I still owned my business, when I still owned the pharmacies, I had an employee dedicated at nothing but prior approvals. That is all they did was prior approvals and it decreases compliance because, you know, I get a prescription from the patient, from the doctor and, I am sorry, I can't

fill it right now, I got to call and get a prior approval on this and then it is three or four days and they don't come back, they don't get it, and they go without it for three or four days, and a lot of times they just don't come back period.

I am telling you, Teddy Roosevelt. That is who we need to vote for.

Mr. Chairman, I yield back.

*Mr. Guthrie. The gentleman yields back and the Chair recognizes the gentlelady from Illinois, Ms. Kelly for five minutes for questions.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member Eshoo for holding today's critically important hearing.

The Second Congressional District is one of the biggest districts in Illinois, covering a travel distance of approximately three hours. From the northern part in Chicago, to southern boundaries. It encompasses a diverse range of area from urban, suburban neighborhoods, to rural.

I have approximately 2,000 farms dotting the landscape of my district and frequently, I receive feedback from

constituents across the district, the challenges they face in accessing healthcare, but this concern is particularly pronounced for those living in the rural corners of my district.

Throughout today's testimonies we have heard that access to physician care for Medicare recipients has shown remarkable resilience in the face of challenges posed by the existing physician reimbursement model.

However, it remains a well-documented fact that individuals residing in rural areas, particularly those in communities of color, frequently encounter obstacles when seeking high quality healthcare.

These difficulties arise from a multitude of factors, with workforce shortages, especially the challenges in retaining physicians in those underserved regions, standing out as a prominent and persistent concern.

Dr. Fiedler, can you elaborate on how the proposed modifications to, excuse me, Medicare's physician payment system, which you discussed during your testimony, might enhance access to healthcare for Medicare beneficiaries in rural communities?

Excuse my voice.

*Dr. Fiedler. So there are, in terms of rural communities, in particular, I'm, you know, broadly speaking. The Center for Medicare and Medicaid Innovation at the moment is considering and it is working on specific ACO models that would provide more generous spending benchmarks to communities that have been historically underserved.

And I think the hope is that those sorts of structures will allow the providers participating in these models to invest more in the care for those communities.

I think those types of efforts are still at the early stages, and so it remains to be seen whether they'll have the intended affects. But I think that's an approach worth watching.

You know, I think these types of provider side interventions are worth exploring. I think it's also worth looking at interventions that would target sort of underserved beneficiaries and disadvantaged beneficiaries themselves.

So one specific opportunity for example is improving the Medicare Savings Programs, which provide cost sharing

and premium assistance to lower income beneficiaries.

*Ms. Kelly. Okay. Thank you.

Dr. Patt, with the end of the public health emergency, CMS has decided practices can no longer delivery oral cancer medications to patients. How has this impacted cancer patients access to treatments? Specifically, again, in rural communities?

*Dr. Patt. Thank you for the question. I think this is a really important one that's happened with the conclusion of the pandemic.

So you know it's an amazing time in cancer care actually. Not only are we able to frequently control cancer or cure cancer, but people are able to live their lives where they work and sleep in their bed and eat dinner with their spouse and pick up their kids from soccer practice. They get to live and it's amazing.

And a lot of that is because the therapies that we give are chronic in nature, oral therapies that they take chronically. For patients, especially rural patients, like the patients you mentioned in your district that have to drive for healthcare, are no longer able to receive mail

order drugs from their doctor, which means if you're on an oral oncolytic like Excipnib [phonetic] or Verzenio or another drug that you take chronically to control your advanced cancer, that you alone have to stop your daily life, drive the three hours into a clinic to pick up your medication, drive your three hours back.

And in that you still get to have your cancer control, but you don't get to live your life, because if you're a rancher or a housewife that lives in rural America, you have to drive and disrupt your daily life in order to receive care.

This is in contrast to the time before _ during the pandemic and before the pandemic when patients could receive their oral medications delivered to their homes and that makes it a lot more convenient.

So this is a challenge and it's a particular burden on rural Americans. And it's growing, because thankfully, due to innovation and America's investment in innovation, we have a lot of oral therapies that control cancer chronically. This represents about 30 percent of the cancer therapies we give today, but we think it's going to grow to

60 percent in the next few years.

So this will be an increasing burden for rural recipients of healthcare and particularly cancer care. I think that it will go a long way to help the healthcare of rural Americans to make official policy to change that, to allow patients to get their drugs by mail from their doctors.

*Ms. Kelly. Thank you so much for your answers and I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The Chair will now recognize Mr. Johnson for five minutes for questions.

*Mr. Johnson. Thank you, Mr. Chairman. Really appreciate this.

You know, we have got a lot of pressing issues before us today with deadlines coming up quickly. Deadlines like the 15 percent cut for approximately 800 tests under the Medicare Clinical Laboratory Fee Schedule that are set to take effect in January.

Thanks to my friend, Representative Richard Hudson for introducing H.R. 2377, the Saving Access to Laboratory

Services Act, or SALSA, that is a play on words, by the way. It is not the dance, but this would create a sustainable path forward for the entire laboratory market protecting patient access, bolstering clinical laboratory infrastructure, and fostering innovation for the next generation of lab services. And I'm proud to co-sponsor this legislation and I look forward to moving this through a markup in short order.

During the COVID-19 pandemic patients were able to have their medications mailed directly to them from their doctor. For folks in rural Ohio, who I represent, this was a godsend. No longer did they have to drive to Cleveland or Columbus or Pittsburgh to pick up their cancer medications from their oncologist.

That flexibility ended with the expiration of the COVID-19 public health emergency. Now, my constituents living in Appalachia must make the hour's long drive to pick up their lifesaving medications and this is absolute insanity.

Thankfully, H.R. 5526, the Senior's Access to Critical Medications Act of 2023, introduced by my colleague Rep.

Harshbarger of Tennessee would make permanent those waivers from the pandemic allowing patients to receive medications through the mail or to have a family member or caregiver pick those medications up at the doctor's office will increase access, save people time and money, and ultimately result in better outcomes.

And I eagerly joined as a co-sponsor when a group of my constituents brought this to my attention and I look forward to helping progress this bill through this Committee and on to the floor.

But let me start my questions with you, Dr. Patt, if I could. Can you describe how this waiver, that I just spoke about, how the waiver helped cancer patients at your practice and how they've been impacted by CMS's recission of the stark waiver following the public health emergency ending?

*Dr. Patt. Yes, sir, and thank you for your leadership and Representative Harshbarger, for your leadership in this. I think this is really important for cancer patients, especially in rural America.

You know, if you look at a practice like Texas

Oncology, we're a large practice. We have many pharmacies throughout the state. And so the patients that it's difficult for them to come up to the practice and get the medicine from our pharmacy, are only those that live in rural Texas.

And I think that that's the case for, you know, across America. When patients live a far distance from the clinic, it's those patients that are disproportionately burdened. It's so extreme that, you know, they can't even send a loved one to go and pick up their medication for them. They have to either not work that day or do whatever they're doing for the day just to go and pick up their medication. Usually medications are filled monthly, and so that's something they would have to do every single month.

And so it's a severe detriment that leads to delays in care because sometimes they can't come on the exact day that they need to come. If we were able to mail order those drugs to patients, they would be able to seamlessly continue their cancer care or other care and then they wouldn't have delays and disruptions. And again, they get to live their life.

They get to be doctors, and lawyers, and teachers, and housewives, and ranchers and do the things that they do in their communities.

*Mr. Johnson. Okay. Is it safe then to say, Dr. Patt, that this requirement, once this waiver is reversed, I mean, now that the waiver is reversed, is it safe to say that the requirement is hurting patients?

*Dr. Patt. I think it's absolutely hurting patients.

*Mr. Johnson. Okay. You know, I had an oncologist in my district. Part of what led me to be such a strong advocate and, thanks to my colleague, Doris Matsui, we were the ones that got these waivers for telehealth and other things put in place, many of them during the pandemic.

And I heard the horror stories from an oncologist. And he made the point _ my families got a history of cancer too. I've got several cancer survivors and a deceased mother who was taken by cancer, liver cancer, a few years ago.

There are no more vulnerable patients in society than oncology patients that are going through chemotherapy. And it's not just COVID that could kill them in a matter of, you know, hours, it's many other things in the critical stages

of chemotherapy.

So I appreciate what you're doing and I appreciate your testimony today, and Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. The Chair recognizes Dr. Schrier from Washington for five minutes for questions.

*Dr. Schrier. Thank you, Mr. Chairman. Thank you to our witnesses today. Thank you for spending your entire day with us.

In my district in Washington and throughout the country we are facing a shortage of doctors, early retirements, resignations, burnout, and that shortage is getting worse. Doctors are facing steep cuts that make it harder for them to see their patients on Medicare while also providing high-value care.

Congress has to act in order to make sure that physicians can keep their doors open for their Medicare patients and so their patients can see their doctors. And I am so eager to work with my colleagues on these issues.

I am a little frustrated that this hearing is focused on so many partisan bills and that the minority has provided

so little opportunity or the majority has provided so little opportunity for us to work on these together, especially when there are already bipartisan solutions that exist.

I am also frustrated, as mentioned earlier, that Dr. Ruiz's bill to tie physician reimbursement to inflation is not included today, because I know that it has broad support from doctors in both parties.

I was really proud to help introduce the Value in Healthcare Act along with another member of this Committee, Dr. Bucshon. It's a bipartisan bill that would help increase participation in value-based programs, that will improve the quality of care and health outcomes, all while lowering costs.

And this bill would extend incentive payments for advanced Alternative Payment Models or APMs, which help them transition to a model of care that focuses on patient health outcomes.

At this time I'd like to ask for a unanimous consent to enter into the record a letter asking for an extension of these incentives from 23 associations and over 600 health systems, hospitals, and physician groups. This has great

support.

Now, one of the bills that the Committee is considering today would also extend these incentive payments. The problem is that it would be at a lower level and with a five-year retroactive cap.

And I am really concerned about placing this kind of cap on providers and I think it will limit the ability to help providers adapt and to implement these programs.

According to the National Association of ACOs, Accountable Care Organizations, the majority of providers in APMs would be negatively impacted by this cap. And so while the transition to Alternative Care Models has been slower than originally anticipated, participation has been growing thanks to this program, and we just can't make it more difficult to adopt these.

The representative from CMS isn't here today, but I just wanted to say that there's a bipartisan plan. I am so eager to work with Mr. Dunn and with this Committee because of the shortfalls in the bill being considered today, I just would request that the Committee reconsider which of these two bills to advance and I would strongly suggest that it be

the bipartisan bill sponsored by Dr. Bucshon.

I also just wanted to touch on Senior's Timely Access to Care. Prior authorization has been a real barrier for seniors and the effort to reform prior authorization process to ensure that it's not coming between seniors and their care has also been broadly bipartisan, and I'm happy it's being brought up today.

Last year the House passed the Improving Seniors Timely Access to Care Act, which would reform this process. CMS has also issued a proposed rule with many similar reforms, and my ask today, and again, it's not to any of you, but would be to get those rules implemented so that we can take care of our seniors as quickly as possible.

I have one minute remaining. If any of you would like to comment on these Alternative Payment Models, on Value-based Healthcare or on Senior's Timely Access to Care.

*Dr. Furr. I agree. You passed that bill last year for the timely access and hopefully it will be passed again this year and move forward. We need that and we need that immediately. Those physician burdens that prior reimbursement is why physicians are leaving their practice

and they go into other types of practice or they're just retiring. They're just dropping out.

We very much support fee-for-service is going to be a thing of the past. We've got to move to value-based models however we do that, but we do know that's the future.

*Dr. Schrier. Sure. At least wherever we can. And getting those rules from CMS, I think, will give us a more accurate assessment of the cost of the program, which would make it easier to get it through, not just the House, but also through the Senate.

*Dr. Patt. I would just say, I think extending the five percent in Advance Alternative Payment Models or Alternative Payment Models does matter. We need to beckon people's participation.

Texas Oncology participated in the Oncology Care Model. We saved the Medicare program over $134 million over nine performance periods, decreased hospitalizations and ER visits, and we've made a lot of strategic investments that have clearly improved the quality of care.

*Dr. Schrier. This is the kind of program we should support.

Thank you and I yield back.

*Mr. Guthrie. The Doctor yields back. The Chair now recognizes Mr. Crenshaw from Texas for five minutes.

*Mr. Crenshaw. Thank you, Mr. Chairman. Thank you everyone for being here and discussing these matters of great importance.

Did my chair just sink? That was weird. Okay. Great.

The reimbursement is key to any problem we deal with in Medicare and figuring it out is obviously important. Obviously, there was some hope that value-based care would simply work better. It obviously comes with some problems, right? It's a subjective way to figure out what that reimbursement is and it's hard to by dynamic and subjective in a bureaucracy.

This is always going to be our problem. I would like us to also think about what the underlying drivers of additional costs are that are requiring us to keep coming up with band aid solutions to make sure our physicians are getting paid enough to maintain their operations.

And so I want to talk about the reporting requirements and the administrative burdens that our doctors face.

This is for you, Dr. Patt. I read a GAO report on the implementation of alternative payment in Medicare and it frequently mentions the burden of reporting requirements. Would you be able to describe for the Committee some of the administrative barriers that practices in your network face when trying to participate in an Alternative Payment Model.

*Dr. Patt. So I think on practice, thank you for the question, so I think that practices face administrative burdens in the quality programs both with reporting for MIPS and in Alternative Payment Models. I think that they're both _ they're both challenging and you have to staff appropriately to have them.

I will say it's particularly challenging right now, and I can't speak for all the Alternative Payment Models pilots, but as you know, in oncology, OCM has changed to EOM and the quepe [phonetic] thresholds are such that _ we actually are participating in EOM, our participation is pretty low, but we'll end up reporting MIPS and reporting everything for EOM. So it's sort of a duplicative administrative burden.

So you actually have to hire extra staff in order to manage this. It's a huge physician burden, in terms of cost

and hours per week, in addition to increasing staffing in the setting of a staffing shortage.

So there's a lot there. I will say that, again, going through the experience of Texas Oncology in the OCM, we've made a lot of strategic investments that took time to make them, but they did actually improve the quality of care that we've measured that's helpful in that process, but the administrative burden is steep.

*Mr. Crenshaw. Yes. And more suggestions from you all on what concrete steps we can take to remove unnecessary administrative burdens that really don't have a positive effect on patient outcomes and that are needless, the Committee would benefit greatly from all of you.

*Dr. Patt. I would say I think that the MIPS program and the reporting that we have in Alternative Payment Model programs, it's a huge reporting burden and that it's _ anything that we can do to lessen that administrative burden to the practices, in terms of the information that we need to submit ourselves, I think we would not have to staff up to be able to participate.

And I think, especially, you know, I can speak for my

group, we're very willing and able to participate in anything to improve the quality of care, but it's been a large burden.

*Mr. Crenshaw. Yes.

*Dr. Patt. The administrative burden of reporting.

*Mr. Crenshaw. But I actually place that burden on you. You got to tell us the details. You know, you have to give us that list of things that are very concrete. We benefit greatly from that.

Mr. Albanese, you want to, in my minute 20 seconds left, you want to just take on that same subject?

*Mr. Albanese. Sure. So I would definitely agree that there is definitely a lot of evidence of increased burden from MIPS particularly. One study had found $13,000 and 200 hours of increased physician time per physician from MIPS alone, whereas a recent literature review did not find any evidence that it actually improves value of care.

So the increased burden and the lack of results on that front, I think, point to a very underwhelming record for MIPS.

*Mr. Crenshaw. Yes. I appreciate that. And what

about, 30 seconds, I want to talk about primary care. I have many physician practices within my district, actually part of Texas Oncology Network, and when we are _ well, I don't have any time. I will yield back. Thank you.

*Mr. Guthrie. The gentleman yields back. The Chair recognizes Dr. Joyce from Pennsylvania for five minutes.

*Dr. Joyce. Thank you, Mr. Chairman. At this point I ask unanimous consent to enter into the record a statement from the American Academy of Dermatology in support of H.R. 2474.

Thank you for being here today. Your impact and your discussion allow us to have better impact as we continue to legislate and look at the burdensome costs that occur with Medicare with the inadequate reimbursement that occurs to so many physicians throughout America.

As a doctor who has practiced in rural Pennsylvania, I witnessed firsthand many of the unique barriers to care affecting our rural and ultimately our underserved communities.

Today in the United States unmet demand in rural areas for my subspeciality, dermatology, is on the rise and not

projected to improve. In fact, HSA estimates 39 percent adequacy in non-metro areas for dermatologists in the short timeframe by 2035.

This raises the unfortunate question of what happens to Americans who don't have access to care? One of the greatest threats to physician access in rural and underserved areas is arbitrary annual cuts to reimbursement for Medicare physician services. Declining reimbursement rates, especially those supported by rigid bureaucratic whims and not actual data are discouraging doctors from treating Medicare patients.

Let me say that again. That annual decrease in costs discourages doctors from taking on Medicare patients. If fewer doctors are available to treat Medicare patients in already underserved areas, then there will be fewer opportunities for preventative screenings leading to delayed diagnosis and ultimately, more cancer patients for you to see, Dr. Patt.

Dr. Patt, you, as a physician, can you tell me how the decrease in Medicare reimbursement impacts your practice and the patients that you see?

*Dr. Patt. Thank you. So we published _ so myself, I was a lead author with Dr. Lusio Gordan and other members of the Committee Oncology Alliance during COVID, a decrease in cancer screenings substantially down because of the pandemic.

And even coming out of the pandemic we recognize that people have had competing priorities as they engage with healthcare. There are fewer doctors to see people because reimbursement is down.

It is more difficult for people to get the care that they need, that they've delayed during the pandemic because availability is less and demand simply outstrips supply.

This leads to difficulty in getting in to see the doctor. This leads to difficulty when you find a breast mass of getting a diagnostic mammogram. This leads to a difficulty in getting a colonoscopy if you have bleeding.

So these natural consequences of this pent-up demand and decreased reimbursement is that there are delays in patients getting care.

I observe that when patients present with their cancer, when they present with a Stage 3C breast cancer because they

knew they had a breast mass, but it was difficult for them to manage getting care and then their cancer is much harder to cure.

So this has been a tremendous burden and it certainly has been exacerbated by the pandemic, but a root cause is the declining reimbursement. That it's not allowed us to scale capacity of medical services and staff to meet the demand that we have.

*Dr. Joyce. Thank you. I also believe that this current trend should be unsustainable, but it's going to yield to decrease access and worse healthcare outcomes, as you just delineated.

Mr. Albanese, in your testimony you acknowledge the need to offset any increases in physician payments with savings from other areas of Medicare Part B. Site neutral payments for services has been one proposal that has received a lot of attention at this Committee and so has reform of the 340B Program.

Could you please elaborate as to how these ideas can be advanced by this Committee without exacerbating financial pressure particularly on rural hospitals and the rural

patients that they serve?

*Mr. Albanese. Thank you, Congressman. I certainly would echo what others on the panel have also said about site neutral payments and reducing the disparity between payments for hospitals and physicians on numerous services, such as drug administration, imaging, and clinic visits, to name a few.

With regard to 340B, this is a discount program where hospitals have been able to achieve 25 to 50 percent in savings and they are not required to pass these savings along to their patients.

But whereas Medicare is required to pay the same amount for these drugs as for other drugs. So I think Congress requiring or at least giving CMS the authority to pay more accurate rates for these drugs would yield huge savings for taxpayers and for patients.

*Dr. Joyce. Thank you, Mr. Albanese, for your response. And again, thank you for the witnesses for what has turned out to be a long day.

Mr. Chairman, I yield.

*Mr. Guthrie. Thank you. The gentleman yields back.

The Chair recognizes the Chair of the full Committee, the Chair Rodgers for five minutes for questions.

*The Chair. Thank you, Mr. Chairman. I too want to just say thank you to all of our witnesses for being here and your patience as we're dealing with an unpredictable schedule.

This has been a very important hearing. One that we have wanted to have for some time. And as you have heard, the theme of the healthcare discussions have been about the need to address healthcare consolidation.

We are hearing from patients, employers, policy experts about consolidation, in so many cases, it's increasing the prices without necessarily improving quality of care. This is directly relevant to the conversation we're having today.

We want to ensure that the healthcare economy can sustain private practice. So I know you have answered a lot of questions, but I just want to go back to Dr. Patt and start with, can you talk about the difficulties of maintaining a private practice in today's environment?

*Dr. Patt. Thank you for your question. I think that for a private, physician-owned practices in the setting of

declining reimbursement. It's very difficult to maintain competitive salaries for staff, to staff your clinic, and stay open.

And the natural consequence of not being able to staff appropriately and having declining reimbursement is that if there's an option to consolidate your practice with a hospital, that that can be an attractive option for private practices because it's difficult to be financially viable independently.

So I think it's a real challenge and I think that many of the issues addressed in this Committee hearing today can help. Site neutrality, making physician reimbursement appropriate that would help that challenge.

*The Chair. Thank you. Mr. Albanese, would you speak to reforms that you believe would reduce incentives to consolidate?

*Mr. Albanese. Certainly. So I can expand a little bit on site neutral payments, which are a major driver of consolidation because hospitals have an incentive then to acquire independent physician offices, rebrand them as off campus outpatient departments and charge a higher rate for

the same services that could be performed in a normal physician office.

So I think targeting those same service areas, as I mentioned before, as well as perhaps removing exemptions to the bipartisan Budget Act of 2015, which set site neutral rates for off campus departments, but exempted those that were already in operation, would be another step towards that goal that was originally envisioned in that statute.

And by doing so, it would help to remove this relative disadvantage to physicians who, as has been noted, seen fewer pay increases over the years compared to hospitals outpatient departments, which is one of the biggest, if not the biggest, growth in spending in Part B.

*The Chair. Thank you. As a follow up, could those reforms be used to help accomplish the goal of making Medicare more sustainable for independent physicians?

*Mr. Albanese. Yes. The Committee for Responsible Federal Budget estimated that pursuing these types of site neutral forms across ambulatory settings would save about $280 billion over 10 years and would save patients over $140 billion in their own out-of-pocket costs as well.

*The Chair. I would like to also ask you, Mr. Albanese, to discuss issues surrounding costs in the Medicare program and if we're achieving our goals related to value?

Could you share if you think APMs have improved the value of care in Medicare?

*Mr. Albanese. Well, I think by CMMIs own admission and has been reinforced by a recent report by CBO, Alternative Payment Models have not been meeting the promise and the optimism that has come with them.

Over the first 10 years of CMMIs operation, CBO had expected about $3 billion in savings, in net Medicare savings. Whereas in reality, over that time, it actually costs the Medicare program more than $5 billion.

It estimated, in the second decade of operation from 2021 to 2030, that these savings numbers would be almost $80 billion, but instead it's going to be net cost of $1 billion.

So I think that's a pretty clear record that very few of the models have actually money as statutorily required. They're required to save money or to improve the quality of

care. And on these fronts, it has been a disappointment.

*The Chair. So are there alternatives to APMs?

*Mr. Albanese. I think that, in Medicare Advantage right now, you see a structure that is very similar to APMs and in value-based care because they receive population-based payments. They're required to pass along the savings that they achieve through bidding to their beneficiaries and their enrollees in terms of more benefits or lower cost sharing.

So these align with many of the same goals as APMs. The difference is that they've actually proven to deliver core Medicare benefits at 83 percent of the cost of traditional Medicare and they have grown in popularity with more than half of Medicare beneficiaries now choosing to enroll in a MA plan.

*The Chair. Okay. Very good. Thank you. Thank you everyone for being here. I yield back.

*Mr. Guthrie. Thank you. The Chair yields back. The Chair now recognizes Ms. Harshbarger from Tennessee for five minutes for questions.

*Ms. Harshbarger. Okay. Thank you, Mr. Chairman.

Thank you all for being here. Dr. Furr, I will start with you. You know, my background is a community pharmacist for over 36 years, but I have done sterile, non-sterile home health hospice and all these things fit right in to the model that I have done my whole life.

And I guess my question to you, sir, is do you think that the differential payment gap between the hospital inpatient perspective payment system and the physician fee schedule has driven physicians out of business and empowered the health system consolidation?

*Dr. Furr. There's no doubt that's a large part of that, along with all the hassles that the physicians have to do in their practice.

So the encouragement is to move in this direction and particularly as our physician population is getting older and the hassles are getting greater and greater, it's just easier to sell out.

*Ms. Harshbarger. Totally.

*Dr. Furr. Not have to deal with the hassles of employees, training your personnel, and even losing money on your business. You can't run a business and then know every

three to four years _ every year you're going to lose three to four percent.

I think we also tend to forget; we're already always losing two percent for sequestration.

*Ms. Harshbarger. Yes.

*Dr. Furr. That was the biggest thing you all did for us during COVID. We got that two percent back and for our primary practice, that makes a huge, huge difference.

*Ms. Harshbarger. Huge difference.

*Dr. Furr. When you're talking about three to four percent? It's massive.

*Ms. Harshbarger. Yes. Well, it's like this, you have to have that person, dedicated person, doing your prior approvals or trying to figure out which generics on a pharmacy benefit manager's formulary. I understand, believe me. I do that in the pharmacy industry too.

Dr. Patt, thank you for being here today because you all have been big advocates on this bill. You know the bipartisan legislation, the Seniors Access to Critical Medications Act.

Who thought you would have to create legislation in

order for a patient, who is critically ill in most cases, to be able to come pick their medicine up, get a family member to pick it up, or us to mail it? It's nuts. But what this legislation does, it modernizes the Stark Law to make permanent that waiver exception issued by CMS that allowed for them to do that.

You know, if you look at it, you could give me story after story, I'm sure, where a patient has missed a dose or they were reluctant to even do the chemo orally initially and then when they found out you couldn't mail it to them, they just didn't get it and then what are the outcomes on that? The outcomes can be detrimental.

*Dr. Patt. Absolutely. So we spoke earlier about the burden to rural Americans receiving cancer therapy, but what we didn't speak about was all of the disabled Americans or, you know, Americans that are ill because of their cancer therapy and they are not able, really, to come in and get it and they can't have a family member come in and it makes it so much better for them if you can mail it to them. It allows them to access care.

So it ends up really being an access to care issue that

disproportionately burdens sick patients, disabled patients, and rural patients.

So again, thank you for your leadership. This would be a monumental improvement to cancer care in America if we're able to successfully pass this legislation.

*Ms. Harshbarger. Yes. And you know, if you look, we are just talking about part of the equation. If you look at what some of the PBMs are doing when you have short-term changes in therapy, you know, and they do a mail order of three months, what's that costing? What is the waste? You know we need to do a study on that, sir.

*Dr. Furr. I encounter that every day in my practice.

*Ms. Harshbarger. Yes.

*Dr. Patt. I say as a breast cancer specialist. So I frequently will start patients on endocrine blockade in addition to something called a cdk 46 inhibitor, it's a pill, to control cancer, and it really improves their progression free survival, but it has a lot of toxicities.

I dose reduce that drug about half the time. And so _

*Ms. Harshbarger. Totally. Yes.

*Dr. Patt. And so when they come back, I don't want

them to have had a refill because that is a multi-thousand-dollar loss, waste.

*Ms. Harshbarger. Multi thousand-dollar waste.

*Dr. Patt. Yes. And it happens half the time, if they're filled with a PBM, but if it's filled in our office and I am able to check in with patient before they get the refill, I am able to manage their dose in a timely fashion.

And that happens every day, you know, in clinic. That is why we see patients. Every day in clinic I make a dose adjustment.

*Ms. Harshbarger. Yes.

*Dr. Furr. And so, based on laboratory values or patient symptoms and if they're getting it mailed to them from the PBM automatically without the doctor being involved, they don't have that tight control and it leads to medical waste.

It's really poorly characterized, but we have so many stories of that well documented.

*Ms. Harshbarger. Well, maybe you need to make sure you continue to get those stories because maybe that is something they need to look at. What is the amount of money

that is wasted. It is easy to fix, isn't it? That is why they call it the art of practicing medicine; you are adjusting as you go.

And I have only got a five seconds left. I have got a lot more on the infusion side too, but it is my pleasure to introduce that bill and I have got another co-signer in Dr. Joyce. So thank you.

I yield back.

*Mr. Guthrie. I told Dr. Meeks she was next, but that's not _ my friend from California came back, so Ms. Barragan from California is recognized for five minutes.

*Ms. Barragan. Thank you, Mr. Chairman.

We have heard today that physician reimbursement under Medicare is not keeping pace with the increasing cost of providing care and this gap is expected to keep growing under current law.

Dr. Furr, how does the gap impact accessibility to quality care, especially for traditionally underserved communities and communities of color?

*Dr. Furr. Well, 44 percent of my practice is African American and many of the others are low income. Their

ability to go elsewhere for care is very limited.

So when those costs for us go up, it's harder to provide the care. And we have the increase administrative burden, we have less time to take care of our patients. And that is why you see a lot of physicians dropping out of practice. Their joy comes from taking care of patients and not clicking boxes.

So it's harder for us to take care of those patients. We need extra staff to do the administrative stuff, which we really need them to be taking care of patients rather than doing the administrative burden.

*Ms. Barragan. Well, thank you. What did you say your percentage was of African American?

*Dr. Furr. 44.

*Ms. Barragan. 44.

Dr. Furr, in addition to adjustments to the Physician Fee Schedule. What are some ways that Congress can better support physicians to help alleviate burnout?

*Dr. Furr. Well, there's a lot with the quality measures. There is one thing that we really want to propose is that there needs to be a standard for quality measures.

Every plan tends to come up with their own different quality measures. So you jump through all these different hoops trying to find out what the quality measure is for this plan.

Some of the quality measures are automatically reported, but some of them we have to manually report. Sometimes you don't even know whether they get the information or not.

So one plan tells me that they get the billed data from labs, so that they know I did an A1C and that the diabetic is controlled. I recently found out another major plan doesn't look at the lab data. So the only way they can find that out is I have to manually report it.

So if they're going to require that, a lot of that needs to be done manually. But also with that, with a lot of the quality things, we're held accountable for things that we don't have any control of.

I can offer a patient a flu vaccine, but I can't make them take it. I can, but I would guilty of battery. But I'm not given credit for offering that. I can put a code in and say I offered this vaccine and patient refused it or

their meaningful other refused it, but it doesn't help me any with my quality.

So one thing that riles a physician more than anything else is being held accountable for things we can't control.

*Ms. Barragan. Got it. Well, Dr. Furr, I understand that physicians face administrative burden when working with patients with complex or chronic conditions such as Alzheimer's Disease.

Now, these patients usually need access to timely care from a variety of physicians and specialties. You've mentioned that implementation of the G2211 code would reduce physician burden and allow for better care for these patients.

How would implementation of the code impact overall care for patients like those with Alzheimer's?

*Dr. Furr. I think the thing is we talk a lot about it for it being primary care, but we're talking about people with chronic problems. So the primary care, if any, physician is not the only ones that would benefit. A nephrologist who takes care of his renal dialysis patients, takes care of them chronically, could also use this code.

And endocrinologist who takes care of diabetes on a long-term basis could use this code. And a neurologist who takes care of a patient with Parkinsons or Dementia could also use this code.

The most important thing about this code is it covers a lot of different areas, but what we're trying to do is take care of our sickest patients, with the chronic problems, and make sure physicians can afford to do that.

I think the most important thing for us, as primary care, we're able to take care of a lot of these problems and then the specialists tell me they're overwhelmed because they're getting too many patients with minor problems. The neurologist is seeing too many basic things that could be taken care in the primary care setting, but there's not enough primary care physicians.

So we could help some of our specialists by having more primary care physicians to take care of those problems upfront.

*Ms. Barragan. Thank you.

Dr. Feidler, I want to talk about Alternative Payment Model design to underserved communities. My district is a

majority minority district and our communities typically experience increased barriers to access quality healthcare.

Doctor, we have heard a lot of positives about Alternative Payment Models today. However, I am concerned about _ I am concerned that these payment models have the potential to exacerbate health disparities, especially for underserved communities and communities of color.

If not designed with these communities in mind, could Alternative Payment Models be designed in a way that recognize physicians working in underserved communities?

*Dr. Fiedler. Yes. So there have been proposals and the Centers for Medicare and Medicaid Innovation is currently testing the ACO Reach Model, which takes an approach in this vein where the spending benchmark set under the model are set higher in areas with large numbers of traditionally underserved beneficiaries.

And the goal being to, by providing a more generous payment environment, to encourage greater investment in care for these beneficiaries.

Those type of projects, I think, are still in the early stages, so it remains to be seen how successful they'll be

in achieving those goals, but that is one strategy that is currently being tested.

*Ms. Barragan. Great. Thank you. My time has expired. I yield back.

*Mr. Guthrie. The gentlelady yields back. The Chair now recognizes Dr. Miller Meeks for five minutes for questions.

*Mrs. Miller-Meeks. Thank you, Mr. Chair.

I thank all of our panelists that are here today. So I am a former nurse, current physician, currently licensed, also a 24-year military vet.

I also practiced, most recently, in a community of 25,000 people and I traveled 30 miles away to another community of 10,000 people to deliver care, in addition to making home visits, in addition to going and picking up people and driving them to my main office, in addition to driving them up to the University of Iowa, so that they could get access to care.

I have done academic medicine, small single specialty private practice, I have done military medicine, and I have been employed by a hospital physician, which is why I was

very proud to co-sponsor H.R. 2474, the Strengthening Medicare for Patients and Providers Act.

And Dr. Furr, as you mentioned, this legislation would provide annual inflationary updates and, Dr. Patt, you also mentioned it, based on the Medicare Economic Index, to physicians who support patients through Medicare Part B.

I feel very strongly about this legislation exactly for the reasons you have said. And so I am just going to ask a very simple question.

Does your organization support this legislation and how could family physicians benefit from an annual inflationary update?

*Dr. Furr. I don't know any physician organization that does not support that.

*Mrs. Miller-Meeks. Thank you. And I would have questions for all of you, believe me.

Dr. Fiedler, you stated that healthcare providers incur substantial cost to interact with insurers, likely totaling hundreds of billions of dollars per year. Costs that are ultimately borne, in large part, by consumers and taxpayers.

And I will say that I have done pre-authorizations,

step therapy, just about everything that I can to reduce the burden on physicians.

How do you think physicians' responsibility to negotiate contracts, collect information about patients' insurance coverage, and battle insurers on prior authorization impact quality and access to care and do you believe the burden is higher for doctors in rural areas and those who operate independent practices?

*Dr. Fiedler. Right. So when we think about the ability of the payment system to incur access to care, there's two sides to that equation. One side is the revenue side, but one side is the cost side of what does it actually cost to deliver that care?

And so if we are imposing more in administrative costs, whether it be quality reporting or prior auth or other things, that means the payment rates are going to need to be higher to achieve the same level of access.

In terms of what we might, you know, what me might do about that. I think there are, particularly in the context of Medicare, I think particularly the merit-based incentive payment system is a clear place to look.

We are imposing very substantial costs, you know, thousands of dollars, as Mr. Albanese said, per physician, per year to comply with this program, and there's very little evidence, unfortunately, that it's having the intended effect of improving the quality or efficiency of care.

*Mrs. Miller-Meeks. Well, thank you for leading me to my next question.

Dr. Albanese, as you pointed out in your testimony, Alternate Payment Models have not lived up to our expectations. Furthermore, APMs have been largely focused on primary care and provided little opportunity for meaningful specialist participation.

Clinical data registries drive healthcare improvements by providing feedback on quality performance and appropriate use metric, including patient outcomes. They can help physicians monitor and manage patient populations, facilitating early interventions and preventative care, which can lead to more successful disease management and less expensive care.

Incentivizing participation in this proactive quality

patient improvement and feedback tool was a congressional priority when it was originally enacted in MACRA. Many specialties and sub-specialties believe that as implemented by CMS, qualified clinical data registries are not being recognized to their fullest potential and are only being used as an option for reporting MIPS measures to CMS.

And I truly wish CMS had stayed her for all of your testimony and answers to questions. Do you believe that CMS has done enough to fulfill congressional intent when it comes to the role of clinical data registries and improving healthcare?

*Mr. Albanese. So I would certainly agree that access to APMs and the APM bonus, by extension, has been uneven among different specialties and different geographic areas.

With regards to MIPS? MIPS, as well as many of the other quality programs across Medicare are very siloed and don't tend to take a comprehensive view of quality improvement.

And the incremental steps that CMS has tried to announce in this space have been slow, in terms of yielding progress. So I certainly think it's important to try and

have more data availability that allows for meaningful measures for patients to compare quality between doctors and providers without simply having government officials decide what their priorities are going to be at the expense of patients.

*Mrs. Miller-Meeks. Thank you. And then, Dr. Patt, really quickly. Do you think Congress overpaying entities through the 340B Program will contribute to the amount that Medicare beneficiaries will spend on premiums?

*Dr. Patt. I do. I think the natural consequence of the $53.7 billion program last year being a reduction in cost is, you know, while we think of it as a burden to manufacturers, if manufacturers are selling 30-ish percent of their drugs at a 50 percent discount, that ultimately that leads to an increase in drug prices, which is a burden born on the backs of American dollars.

*Mr. Guthrie. Thank you. Dr. Miller Meeks yields back and I haven't asked questions yet.

We typically go in order, but I knew I would be here to the end, so I wanted to make sure [inaudible] moving forward.

Dr. Bucshon, you have asked questions? Okay. Dr. Burgess has as well. So I will now recognize myself for five minutes for questions.

So Dr. Patt, first for you. Did your practice participate in the Oncology Care Model, OCM, that was developed through CMMI and can you share some of your specific results? And why do you think CMS chose not to continue the OCM and instead pivot to the Enhanced Oncology Model?

*Dr. Patt. Thank you for the question. Texas Oncology did participate in the OCM Program, which was the Alternative Payment Model pilot for oncology. We save _ it was a successful program for Texas Oncology and for Medicare.

For us, we saved the Medicare Program $134 million over nine performance periods. We substantially reduced ER visits and hospitalizations. I think nine percent and six percent, but the official numbers are in my written testimony.

But I will say that differently than that. We had strategic investments in improving care quality that, I

think, mattered for patients.

For example, content education about their specific cancer and therapy, I think, improved health literacy for patients that led to increased compliance with oral therapies.

The implementation of electronic patient reported outcomes instruments and that kind of remote therapy monitoring allowed us to improve hospitalizations and ER visits and lower costs, within that subset of the whole population that we improved ER visits, hospitalizations, and reduced costs.

So I think that, for us, that's been a success. Such a success that we chose to implement all of those initiatives for the entire practice and we've chosen to continue them. We are participating in EOM.

I think that the reason why OCM wasn't continued is because overall the program was felt to be a failure because it failed to save Medicare money overall. I think that we need to do a deeper dive into that data to understand who is saving money to the Medicare program and who is not.

I know since we, as a private practice, are a lower

cost site of service, that there may be some winners or losers and that endeavor that we might benefit from a better biopsy of that to try to understand better what we're winnings from the OCM and what were _

*Mr. Guthrie. Well, you are time [inaudible] exactly. I have got three minutes. So I want to direct this question to you, but anybody that would like to answer from the panel, because I think it is important and it gets exactly to what you were just saying.

When CMMI was stood up, it was estimated that if we spent $10 billion to create this agency it would save $30 billion, therefore you could book 20 and spend in the same bill. That is kind of the way we do things here unfortunately.

But despite that, CBO came out, says it didn't save the 20 billion, it actually had, or 30 billion, which is the net 20, but it actually has cost money. How can CMMI ensure they are driving value and doing what they are supposed to?

I was over to Dr. Patt and then I would love to have anybody else talk about it till the two minutes are up.

*Dr. Patt. Well, just some things that I would say is

that I think that practices need nudges to participate and engage in real ways. And you know, to _ we tested one model in oncology, there are other Alternative Payment Models that have been proposed to PTAC that also might help practices transform that I think could be considered and that would be a really reasonable way to think about how we study different models and what impact they have on medical care and cost.

*Mr. Guthrie. I see Mr. Albanese is reaching for his button and Dr. Fiedler, so whichever would like to go first.

*Dr. Fiedler. Yes. So one comment is, you know, I think one of the challenges CMMI has faces is it had relied on primarily on voluntary models and that has forced CMMI to design models in such a way that the federal government captures a fairly small share of the savings from these models and also may force them to make other changes that I think dull practices incentives to actually save money under these structures.

So CMMI could think about making more use of mandatory models, or one could think about creating stronger incentives for participation in these models in the first

place through things like the existing APM bonus.

*Mr. Guthrie. Okay. Thanks.

Mr. Albanese?

*Mr. Albanese. I would say that the reevaluation of CBO's assumptions in its recent report provides an opportunity for Congress to look at ways to provide more oversight of the office, particularly because the $10 billion appropriations that it gets every decade are a major driver of those costs; that funding should be revisited and there should be more standards from Congress and more oversight on transparency for its evaluations; when models should be terminated, rather than revised; and when they should be expanded; whether they should meeting a net savings goal rather then just a budget neutrality goal.

So there's numerous ways that Congress can do this, particularly because CMMI has unprecedented power, in terms of government agencies, not facing traditional review or administrative review, in terms of its ability to change Medicare law and waive Medicare law in order to stand up its models, I think it makes sense to try and provide some counterweight to that.

*Mr. Guthrie. Thank you.

Dr. Furr, do you have any comments? I only have a couple of seconds, but _

*Dr. Furr. I would just say concerned with any incentive program or advance payment model is often the government gives a small carrot and a big stick, so that you got a limited upside, but you got a lot of downside. You might be two percent up, but you might have a nine percent down.

So I think _ and when I've talked to physicians who've tried it, often the work is not worth the effort and they feel like they're going to get bludgeoned at the end. So I think you've got to make the incentives worthwhile.

And the other problem, for smaller practices, they just don't have the resources to do that. They're overwhelmed with all the other things. So even to talk about adding another level of work, even though there might be some savings, because if it gets done in my practice, I've got to do it.

*Mr. Guthrie. Thank you. Thank you, Dr. Furr.

I yield back.

Seeing no other member presenting themselves for questions, I will now conclude questions and ask unanimous consent to insert in the record the documents included on the Staff Hearing Document List. I think you guys have had that list.

Without objection, that will be an order.

And I remind members that they have 10 business days to submit questions for the record and that we ask that the witness will respond promptly to the questions.

Members should submit their questions by the close of business on November the 2nd. And without objection, and I want to say thank you, before I say that, before we adjourn, thanks so much. It is a fluid day; it is a fluid time.

This is unprecedented time here in Washington and we appreciate your patience, your willingness to travel as far as you have to be here. Some of you are more local than others and it means a lot and thanks for your patience.

And without objection, the Subcommittee will be adjourned.

[Whereupon, at 4:23 p.m., the Subcommittee was adjourned.]