Written Testimony on Hearing:

Health Legislative Hearing: "What's The Prognosis?: Examining Medicare Proposals To Improve Patient Access To Care & Minimize Red Tape For Doctors"

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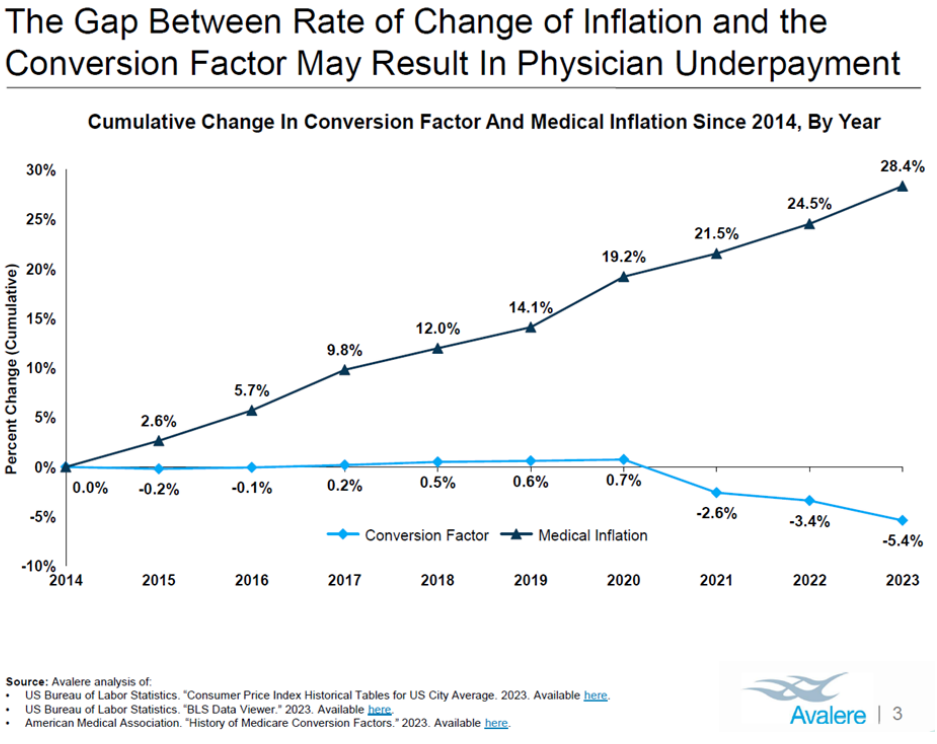
One Page Summary of Written Testimony

- Continued Medicare fee schedule payment cuts pose real and serious threats to seniors and disabled Medicare beneficiaries accessing medical care. Decreasing reimbursement causes a chain reaction that results in provider network inadequacy, decreased access to care, inability to manage staffing shortages, and decreased quality of care for American seniors and other 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 documented in driving up the cost of medical care for all Americans.
- Since 2014, medical inflation has increased substantially every year, yet Medicare reimbursement (as measured by the Medicare conversion factor) has only decreased. The ever-widening gap between the inflation rate and Medicare payment can be seen in the graph below of the cumulative change in conversion factor and medical inflation by year since 2014. Medical inflation has risen by 28.4 percent while the conversion factor has had a 5.4 percent decrease.



Source: Avalere analysis of:
- US Bureau of Labor Statistics. "Consumer Price Index Historical Tables for US City Average. 2023. Available here.
- US Bureau of Labor Statistics. "BLS Data Viewer." 2023. Available here.
- American Medical Association. "History of Medicare Conversion Factors." 2023. Available here.

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- The pressures on independent physicians today, exacerbated by unrealistically low Medicare reimbursement and the MACRA debacle, is leading to increased physician burnout. According to a recent study, over 145,000 healthcare practitioners left the health care industry from 2021 through 2022, threatening access and quality of medical care. Of this number, 71,000 were physicians who dropped out of the workforce in just this two-year period.
- The burden of declining reimbursement has been exacerbated by a national crisis in shortages in healthcare staffing. Just last week, it was announced that after a three-day strike, Kaiser Permanente has agreed to a pay increase for nurses and ancillary staff of around 21 percent over five years. Staff turnover and shortages contribute to access and quality of care for all Americans, not just Medicare beneficiaries.
- CMS is vastly overpaying 340B hospitals for cancer drugs and other expensive therapies. Rather than using hospital survey data on 340B discounts, which CMS has collected and reported on, CMS has chosen to ignore that data and instead is overpaying 340B hospitals by close to 50 percent. This has already increased drug costs for Medicare beneficiaries. Now with CMS paying 340B hospitals a $9 billion bolus for 340B "remedy" payments, by CMS' own admission this is contributing to a 6 percent premium increase Medicare beneficiaries will have to pay in 2024.

Chairman Guthrie, Ranking Member Eshoo, and members of the Health Subcommittee of the House Committee on Energy & Commerce, I appreciate the opportunity to submit this written testimony and to be asked to appear as a witness at this extremely important hearing.

I frame this written testimony, opening statement, and answers to questions from the perspective of an oncologist specializing in the treatment of women with breast cancer. I also serve as an Executive Vice President of Texas Oncology and Vice President and Board member of the Community Oncology Alliance.

Testimony Background

Let me take you into the life of an independent, non-hospital employed community physician in 2023. As a breast cancer specialist, I am still dealing with the aftereffects of a dramatic drop-off in mammograms and other cancer screenings during the COVID pandemic, which has resulted in more and more advanced cases of cancer. One study I helped co-author with COA found significant reductions in breast (-85%), colon (-75%), prostate (-74%), and lung cancer (-56%) screenings at the first peak of the pandemic in April 2020, compared with April 2019. As this

committee is all too aware of, the treatment of many types of cancer have also been extremely complicated by the ongoing life-threatening shortages in essential generic sterile injectable cancer drugs. As this weren't enough, the pressures are mounting by insurers and their pharmacy benefit managers (PBMs) to dictate via prior authorizations what therapies I can use and both where and how they are administered. It's a fight daily I have to have to ensure that the women I care for are given the optimal treatment to ensure they can live life to the fullest.

I work in the independent, community oncology setting where hospitals are consolidating into large health systems and pressuring independent physicians like me into being absorbed into these much-more expensive settings for cancer care. With non-profit tax status, 340B Drug Pricing Program discounts, facility fees, and grossly higher charges for the same treatments that I provide in my practice, these large non-profit/tax-exempt entities that are hospital based have a decided competitive advantage over independent medical practices. Unfortunately, the federal government just worsens this picture with payment policies for Medicare that have greatly contributed to the consolidation of care into the more expensive hospital setting and that are disincentivizing people from pursuing a career in medicine, which is entering a crisis phase. And the Centers for Medicare & Medicaid Services (CMS) is now threatening me with Stark law violations to stop us from delivering oral cancer drugs to our patients. Thanks to this CMS interpretation, patients dealing with cancer are required to come into our practice to pick up their prescriptions themselves and aren't even allowed to have a caregiver, family member, or friend pick up the patient's drugs. This particular burden is particularly hard for patients in rural areas that have to drive several hours to reach a clinic.

These are just a summary of the challenges we face as physicians on a daily basis. It's not enough that cancer is an unrelenting foe but the "system" – including the federal government – is working against us and our patients.

Inadequacy of Medicare Reimbursement

Continued Medicare fee schedule payment cuts pose real and serious threats to seniors and disabled Medicare beneficiaries accessing medical care. Decreasing reimbursement causes a chain reaction that results in provider network inadequacy, decreased access to care, inability to manage staffing shortages, and decreased quality of care for American seniors and other Medicare beneficiaries. Because reimbursement is low in the Medicare program, beneficiaries have difficulty finding primary care and specialty care clinics that will serve them. Given the disproportionate burden felt by non-hospital affiliated independent practices like mine, the disparity in reimbursement is fueling consolidation into hospital systems that are documented in driving up the cost of medical care for all Americans.

For years, we physicians fought sustainable growth rate (SGR) Medicare reimbursement cuts that were the sword of Damocles hanging over our heads, begging Congress to stop these cuts at the end of each year. Ironically, we now have a new SGR in Medicare payment cuts caused by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which as you know was legislation signed into law on April 16, 2015. MACRA created the Quality Payment Program (QPP) that:

- Repealed the SGR;
- Changed the way that Medicare rewards physicians for value of care versus volume of care;

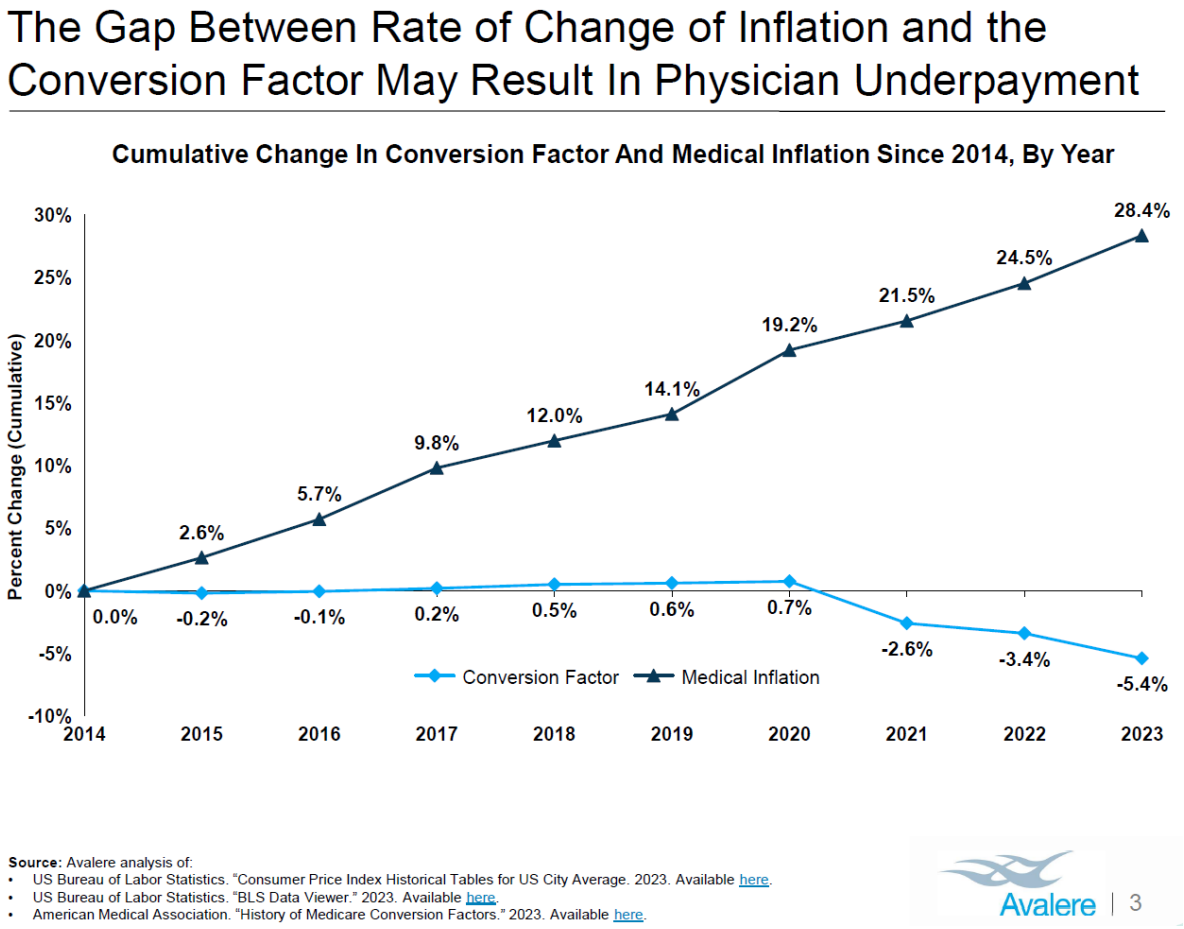
- Streamlined multiple quality programs under the Merit Based Incentive Payments System (MIPS); and
- Provided bonus payments for participation in eligible alternative payment models (APMs).

Unfortunately, studies have shown that MIPS is both financially and administratively burdensome. A 2019 study entitled *"Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System [(MIPS)]: A Qualitative Study"* published in the *Journal of the American Medical Association* found that MIPS costs practices $12,800 per physician per year and physicians spend 53 hours a year on tasks related to MIPS.

Additionally, studies have questioned whether MIPS appropriately evaluates the quality of care or even advances the value of care they receive. An article entitled *"Association Between Individual Primary Care Physician Merit-based Incentive Payment System Score and Measures of Process and Patient Outcomes"* found that physicians serving complex and socially vulnerable patients received lower MIPS scores despite providing high-quality care. Other studies found that MIPS may worsen health inequities. A study entitled *"Association Between Patient Social Risk and Physician Performance Scores in the First Year of the Merit-based Incentive Payment System"* found that in the first year of MIPS, physicians with the highest number of "socially disadvantaged" patients had much lower MIPS scores.

Making matters worse, since 2014, medical inflation has increased substantially every year, yet Medicare reimbursement (as measured by the Medicare the conversion factor in the annual physician fee schedule) has only decreased. The ever-widening gap between the inflation rate and Medicare payment can be seen clearly seen in this graph of the cumulative change in conversion

factor and medical inflation by year since 2014. This analysis was conducted for COA by Avalere Health and found that medical inflation has risen by 28.4 percent while the conversion factor has had a 5.4 percent decrease.



In the 2024 Physician Fee Schedule proposed rule, CMS is calling for another 3.34 percent reduction in physician payment. A significant driver of this cut is implementation of the new evaluation and management (E/M) add-on code for complexity. While we are glad CMS is recognizing that the physician fee schedule does not adequately reimburse physicians delivering comprehensive, team-based care, implementation of this code will benefit some specialties at the expense of others, due to the statutory budget neutrality adjustment. We appreciate the draft reforms contemplated today that would increase the threshold for budget neutrality adjustments and add stability to the physician fee schedule. We saw a similar impact from the implementation

of the clinical labor pricing update which disproportionately impacted capital-intensive specialties like radiation oncology. We appreciate Representatives Bilirakis and Cardenas' leadership to help mitigate the impact of these cuts with H.R. 3674, the Providing Relief and Stability for Medicare Patients Act.

Network Adequacy, Quality of Care, and Physician Burnout

CMS' constantly cutting Medicare reimbursement for physicians has natural consequences that harm American seniors and disabled beneficiaries as it results in decreased access to care through network inadequacy. Today, an increasing number of primary care and specialty care doctors will only see a very limited number of Medicare beneficiaries, or they won't see Medicare patients at all due to decreasing reimbursement. It is increasingly difficult for Medicare seniors to find primary care doctors and some subspecialists because reimbursement is so poor that medical practices have to limit their exposure to Medicare beneficiaries to stay in business by being financially viable. I frequently have breast cancer patients who cannot find primary care physicians who accept new Medicare patients and I have to try to scramble to find physicians to take care of them. Trying to find my patients physicians who take Medicare or even helping them by refilling their other, non-cancer medications during or in between visits leads to fragmentation, delays, and detours in care. This is not a Medicare system operating in the best interest of seniors and other beneficiaries.

The pressures on independent physicians today, exacerbated by unrealistically low Medicare reimbursement and the MACRA debacle, is leading to increased physician burnout. According to a recent study, over 145,000 healthcare practitioners left the health care industry from 2021 through 2022, threatening access and quality of medical care. Of this number, 71,000 were physicians who dropped out of the workforce in just this two-year period. *This is alarming!* And

while reimbursement is decreasing, documentation burdens and complexity of the work burden is increasing.

Staffing Shortages

This burden of declining reimbursement has been exacerbated by a national crisis in shortages in healthcare staffing. Just last week, it was announced that after a three-day strike, Kaiser Permanente has agreed to a pay increase for nurses and ancillary staff of around 21 percent over five years. When physician reimbursement keeps ratcheting down, and is further eroded in real terms by increasing inflation, how are pay increases for staff going to be funded? Staff turnover and shortages contribute to access and quality of care for all Americans, not just Medicare beneficiaries. In my specialty, women with breast cancer cannot schedule mammograms because radiology centers do not have appropriate staffing to conduct mammography. Additionally, independent community oncology practices are often forced to close treatment facilities or limit hours of operation due to staffing shortages.

We are on the verge of a major crisis in medical care and we at best just "fiddling as Rome burns."

Consolidation and Costs

Independent physician reimbursement cuts adversely impact the entire health care ecosystem. However, because hospital systems receive an annual Medicare inflation adjustment, and physicians in private practice do not, the ever-widening gap between independent physician and hospital reimbursement, is contributing to consolidation of medical care into the more expensive hospital setting. With Medicare, hospitals are reimbursed for the same services we provide in our clinics costing Medicare and its beneficiaries more. This gap is even wider for Americans with commercial insurance, especially the outrageous mark-ups for both drugs and services hospitals

have been documented in taking. This is especially true with 340B hospitals as a study of the top 340B hospitals shows that some mark-up cancer drugs an unbelievable five times — meaning a cancer drug costing the hospital $5,000 is marked-up on average to $25,000.

I want to make one last important point about the 340B program. CMS is vastly overpaying 340B hospitals for cancer drugs and other expensive therapies. Rather than using hospital survey data on 340B discounts, which CMS has collected and reported on, CMS has chosen to ignore that data and instead is overpaying 340B hospitals by close to 50 percent. This has already increased drug costs for Medicare beneficiaries. Now with CMS paying 340B hospitals a $9 billion bolus for 340B "remedy" payments, by CMS' own admission this is contributing to a 6 percent premium increase Medicare beneficiaries will have to pay in 2024.

Need to Pass Meaningful Legislation

The Committee is considering very meaningful legislation during this hearing. 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 a 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 340B payment system, both which will pay for much needed physician reimbursement increases. Additionally, Congress needs to address abuses by insurers and their PBMs, including stopping excessive prior authorizations that hinder quality and timely cancer care.

Increasing Provider Participation in Value-Based Payment Models

Texas Oncology is a leader in value-based care. My practice was a leading participant in the Oncology Care Model, an alternative payment model from the Centers for Medicare and Medicaid

Innovation (CMMI) running from 2016-2021 for Medicare beneficiaries undergoing chemotherapy. In this model, Texas Oncology saved Medicare $134 million over 9 performance periods. Hospital admissions dropped from 25 percent to 16 percent. Visits to the emergency room by Texas Oncology patients declined from 24 percent to 18 percent. We are also participating in the Enhancing Oncology Model (EOM), the follow-on model to OCM, which started on July 1. Both EOM and OCM are total cost of care models, meaning we are responsible for any costs a patient encounters during an episode, not just the cost of their cancer treatment. Both models feature risk arrangement options that could meet the criteria for Advanced APM status.

The passage of MACRA was well-intentioned as a replacement to the years of threatened payment cuts stemming from the "Sustainable Growth Rate," and we appreciate the work by Congressional Committees to take stakeholder feedback to craft the final policy. The original timeline envisioned by MACRA was to provide steady payment to physicians while ramping up the program (2015-2019), create opportunity for incentive payments through the Merit-Based Incentive Payment System (MIPS) and the APM Qualifying Participant (QP) bonus to increase participation in value-based care arrangements and activities (2020-2025), and then transition to a more modest conversation factor after the program was further established (2026 and beyond). It was expected that by payment year 2026 (performance year 2024), enough providers would be participating in and receiving shared savings from APMs that the modest increase would be an appropriate update for future years.

Unfortunately, the goals of the statute have not been realized on this timeline. This is due to several reasons. During a key part of this timeline, we experienced a global pandemic that was hugely disruptive to the medical community. Moreover, practice transformation takes time, even for the most sophisticated, well-resourced practices that are committed to the goals of value-based care.

Physician practices face additional challenges today with high inflation rates, staffing shortages, and rising practice expenses.

Under MACRA, providers that participate in an Advanced APM and achieve QP status are exempt from MIPS and eligible to receive additional financial incentives. To achieve QP status currently, participants must receive at least 50 percent of Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM. However, providers are continuing to face challenges meeting the current criteria to achieve QP certification and the thresholds are set to increase in January. According to CMS, for OCM participants, the average payment threshold score was 53 percent (just barely meeting the 50 percent threshold for QP status), and the average patient threshold score was 21 percent (far below the 35 percent threshold). Compared to the OCM, because the EOM includes a smaller, targeted list of 7 cancer types, there will inevitably be a smaller population of payments and patients, making the existing targets challenging to achieve and the higher thresholds nearly impossible to meet. The EOM also requires participating practices to accept 2-sided risk on Day 1 and reduces the upfront payment amount to fund the enhanced services required by the model.

Overall, practices are being asked to do more with less (while taking on more risk) at the same time that the reward for participating is scheduled to decline. If Congress wants more physicians to participate in risk-bearing, alternative payment models, that risk must be recognized. QP status with AAPM bonus must be a viable option for high performing practices who would like to opt out of MIPS. Therefore, we appreciate that Congress is considering extending the APM bonus and current QP thresholds for an additional year and looking at additional ways to encourage participation.

As we look to the future for new models or ways to encourage broader participation in value-based payment models, stability in the Physician Fee Schedule remains key. Reliable, sufficient

reimbursement is the foundation for advancing innovative payment models. Without payment certainty and predictability, independent physician practices will be reluctant to take on additional risk. Additionally, it is critical that APMs are designed with enough flexibility to allow participation from all providers that comprise our healthcare delivery system. Many physician practices, particularly those in rural and underserved areas, may be enthusiastic about the premise of value-based care but simply lack the resources to pursue it.

Other considerations that may also increase provider participation include making the introduction and testing of new APMs must be voluntary. A voluntary model can be phased-in and iterative to allow more sophisticated practices to test the model before expanding it to practices that may have less resources. Stakeholder engagement and physician-buy in is also critical and must remain a cornerstone of any transition to new payment models. If providers are able to fully understand a model's impact on their practice's financials and benefit to patient care, they are more likely to embrace the model. Finally, practice transformation takes time and resources. In addition to financial investment, the OCM demanded a fundamental shift in the delivery of patient care, including the scope and coordination of the care team. It can take several performance periods before we see meaningful changes in key metrics. In summary, we continue to support MACRA's goal of tying payment to quality and are hopeful this goal can still be sought through more predictable payment updates and improved incentives and updates to the Medicare Quality Payment Program.

I want to especially call out the need to pass H.R. 5526, the *Seniors Access to Critical Medications Act*, to allow practices to deliver critical cancer drugs to our patients.

It is critical for this committee and the entire Congress to understand how reimbursement and related financial issues are adversely impacting the access and highest quality of care that Medicare beneficiaries and all Americans deserve.

I appreciate your time reading the challenges faced by independent physicians today as we consider the prognosis of the Medicare program and how it impacts seniors and all Americans. Please take action to prevent the chain reaction that is resulting in consolidation fragmentation, delays and detours in medical care, and increasing costs to everyone.

I appreciate the opportunity to provide this testimony.

Debra Patt, MD, PhD, MBA