STATEMENT OF

MEENA SESHAMANI, MD, PhD

DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR MEDICARE

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE PHYSICIAN PAYMENT

BEFORE THE

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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 & Medicaid Services' (CMS's) efforts to improve the Medicare program. We know the tremendous opportunities that Medicare's quality and payment programs have to contribute to the meaningful, sustainable changes necessary in our health system to put the person at the center of care. Our goals for Medicare include driving high quality, person-centered care; promoting affordability and the sustainability of the Medicare trust funds; and advancing health equity while engaging our partners and the communities we serve.

Medicare Physician Payment

Medicare payment policy is set in statute by Congress, and CMS works within the confines of the law to establish payment polices for physicians and other health care professionals. Since 1992, Medicare payment has been made under the Medicare Physician Fee Schedule (PFS) for the services of physicians and other billing professionals. Physicians' services paid under the PFS are furnished in a variety of settings, including physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Payment is also made to several types of suppliers for technical services, most often in settings for which no institutional payment is made.

Under the PFS, for most services furnished in a physician's office, Medicare makes payment to physicians and other professionals at a single rate based on the full range of resources involved in furnishing the service. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for work, practice expense, and malpractice expense. These RVUs become payment rates through the application of a conversion factor. Geographic adjusters (geographic practice cost indexes) are also applied to the total RVUs to account for variation in costs by geographic area. Payment rates are calculated to include an overall payment update specified by statute.

Driving High Quality, Person-Centered Care

Since its inception in 1965, Medicare has been leading the way in providing affordable, quality coverage, playing a key role in the health and financial security of more than 67 million Americans.[1] As the largest single purchaser of health care – with one in every five health care dollars paid by the program – Medicare serves as a transformative force in the United States.

Over the last decade, Medicare accelerated participation in value-based care – those models that reward better care, smarter spending, and improved outcomes. In 2022, the Medicare Shared Savings Program, established by the Affordable Care Act, saved Medicare approximately $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 (ACOs) maintained high ratings for quality of care. CMS has worked to align policies under the Medicare Shared Savings Program and under the Center for Medicare and Medicaid Innovation's (CMS Innovation

[1] Fiscal Year 2024 HHS Budget in Brief, accessible at: https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf.

Center) ACO models. For example, the advance investment payments finalized for calendar year 2023 are derived from learnings from the ACO Investment Model, a CMS Innovation Center model that tested the effects of making advanced payments of shared savings to certain ACOs participating in the Shared Savings Program. Incorporation of advance investment payments into the Shared Savings Program payment methodology is an example of how our larger ACO strategy of having the CMS Innovation Center test new payment and service delivery models on the Shared Savings Program "chassis" can better harmonize policies across Medicare ACO initiatives and enable us to scale any findings.

ACOs had a higher average performance on quality measures compared to similarly sized clinician groups not in the program. The promise of these care models became even more evident during the pandemic. Many ACOs, including ACOs participating in the Medicare Shared Savings Program, invested in care managers and community health workers who provided critical support to communities struggling to stay healthy. They were able to work quickly to transition to telehealth and continue to provide needed access to care. They provide the team-based services needed to address the full spectrum of issues arising from the pandemic, ranging from community prevention and health-related social needs to end-of-life support for patients, their families, and caregivers. They've demonstrated that better care coordination, providing care not just within the four walls of a hospital, but across the unique experiences of a person, is key to keeping people healthy.

Building on this foundation, we are working across CMS to enhance the movement towards value-based, high-quality care and to ensure that we are all rowing in the same direction so that

100 percent of people with Original Medicare will be in a care relationship with accountability for quality and total cost of care by 2030. We know that when value-based care programs are not aligned, it can be confusing and counter-productive for providers who see patients across a spectrum of payers, and it can create unnecessary confusion for people with Medicare who stand to benefit from the improvements in quality, increased support in managing health and social needs, and coordination across health care providers.

As part of this effort to drive alignment of value-based care models and programs, CMS is making progress on aligning quality measures. CMS has created a Universal Foundation of quality measures that will apply to as many CMS quality-rating and value-based care programs as possible. It is intended to focus providers' attention on measures that are meaningful for the health of broad segments of the population; reduce provider burden by streamlining and aligning measures; advance equity with the use of measures that will help CMS recognize and track disparities in care among and within populations; aid the transition from manual reporting of quality measures to seamless, automatic digital reporting; and permit comparisons among various quality and value-based care programs, to help the agency better understand what drives quality improvement and what does not.

The Center for Medicare is also working with the CMS Innovation Center, as part of the Innovation Center's Strategy Refresh,[2] to expand the number of providers participating in advanced primary care and accountable care programs, to align accountable care initiatives across CMS, and to use the Innovation Center's authority to test innovative payment and service

[2] CMS Innovation Center Strategy Refresh available at: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper.

delivery models that, if successful, could be expanded through rulemaking, including on a nationwide basis, which would make successful models available to more people with Medicare.

Additionally, the Center for Medicare, Center for Clinical Standards and Quality, and the Innovation Center are working together to help clinicians who are a part of the Quality Payment Program – both primary care and specialists – continue to drive towards value-based, high-quality care. We must also leverage stakeholder engagement, for example through listening sessions and our communications channels, so that providers and people with Medicare better understand these care models and can provide more input into how they are implemented. We must also continue to build our shared learning collaboratives so we can encourage innovation and transformation in care delivery and evaluate and harness lessons learned.

This year, CMS is continuing to promote whole-person care in the Medicare Shared Savings Program, the largest ACO program in the country. In July 2023, CMS proposed changes[3] that would help grow this successful program by promoting participation among health care providers, promoting health equity, especially in rural and underserved areas, improving access to coordinated, efficient, and high-quality care provided by ACOs for more people with Medicare.

In particular, CMS proposed to increase the number of people receiving high-quality, accountable care by assigning more people who receive care from nurse practitioners, physician assistants, and clinical nurse specialists to ACOs. In addition, CMS proposed changes to

[3] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/d/2023-14624

encourage participation by ACOs caring for medically complex, high-cost beneficiaries to join the program. These changes, if finalized, would further advance CMS's overall value-based care strategy of growth, alignment, and equity, building on changes finalized in 2022, which included the establishment of advance investment payments for certain ACOs in rural and underserved communities, more time to transition to downside risk, and a health equity adjustment that rewards excellent care delivered to underserved communities. In total, these proposals would be expected to increase participation in the Medicare Shared Savings Program by roughly 10 to 20 percent, which would provide additional opportunities for beneficiaries to receive coordinated care from ACOs.

We know that primary care is instrumental in the delivery of high-quality, whole-person care. Increasing the investment in the nation's primary care infrastructure has been a goal across CMS programs, including Innovation Center models. CMS recognizes the value and inherent complexity in primary and longitudinal care and has proposed to implement new payment and coding to pay for these services accurately and appropriately through an add-on code. In crafting this proposed policy, we carefully considered feedback about how best to implement our proposals, balancing our goals of strengthening primary care and interested parties' concerns about the redistributive impacts of our proposed policy. As we move forward through the rulemaking process, CMS looks forward to reviewing comments received from stakeholders across the industry and from Congress to inform our final decisions.

CMS is further driving quality care and advancing value by linking clinician payment to performance on certain metrics. The Medicare Access and CHIP Reauthorization Act of 2015

(MACRA) established the Quality Payment Program, which consists of two participation tracks: Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Through MIPS, CMS is authorized to implement positive, neutral, or negative payment adjustments based on a clinician or group's performance in 4 categories: Quality, Cost, Improvement Activities, and Promoting Interoperability. In MIPS clinicians can participate as individuals, groups, or in many cases as part of MIPS APMs such as the Medicare Shared Savings Program. In Advanced APMs clinicians participating in certain Innovation Center models that achieve a certain status would receive automatic positive adjustments. CMS is working to cohesively advance these programs (traditional MIPS, Shared Savings Program and Advanced APMs) through the alignment of metrics, reduced burden, and a transition to the use of interoperable data and data systems, as well as layered incentives where feasible. In addition, CMS has aligned primary care metrics across these programs, and is leveraging the new MIPS Value Pathways (MVPs). MVPs are sets of measures and activities related to a given specialty or episode of care that allow for a more meaningful assessment of clinicians' performance. MVPs are developed with extensive input from stakeholders and specialty groups. CMS also proposed changes to align the Quality Payment Program with the Universal Foundation, to drive change more effectively.

CMS also proposed[4] coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel. These proposed services are aligned with the HHS Social Determinants of Health Action Plan and also help implement the Biden-Harris Cancer Moonshot goal of every

[4] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/d/2023-14624.

American with cancer having access to covered patient navigation services. Specifically, we proposed to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. While these care support staff have been able to serve as auxiliary personnel to perform covered services incident to the services of a Medicare-enrolled billing physician or practitioner, the services described by the proposed codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists.

Promoting Affordability and Sustainability

CMS proudly serves as a responsible steward of public funds. We are working to ensure that Medicare remains affordable for people and sustainable for future generations while continuing to improve payment accuracy and address fraud, waste, and abuse. The Inflation Reduction Act of 2022 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.

As of January this year, people with Medicare prescription drug coverage who use insulin now pay no more than $35 per one-month supply of covered insulin. The President's Fiscal Year (FY) 2024 Budget builds on this progress by proposing to extend this $35 cap on insulin products for a monthly prescription to group and individual market plans. Additionally, as of January, people

with Medicare drug coverage pay nothing out-of-pocket for adult vaccines recommended by the Advisory Committee on Immunization Practices, including vaccines for shingles, whooping cough, tetanus, and more.

In September, CMS announced[5] the list of 34 prescription drugs for which Part B beneficiary coinsurances may be lower between October 1 – December 31, 2023. Some people with Medicare who take these drugs may save between $1 and $618 per average dose starting October 1, 2023, depending on their individual coverage. CMS, through the implementation of this law, continues to lower out-of-pocket drug costs for some people with Medicare by protecting them from sudden out-of-pocket cost increases when drug companies raise prices faster than the rate of inflation. These are some of the many ways we are helping to strengthen Medicare now and in the future.

Advancing Health Equity

Profound health inequities have persisted in the United States for generations, and many of these inequities were laid bare by the COVID-19 pandemic.[6] 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. Building on the agency's commitment to health equity, CMS has capitalized on learnings from the CMS Innovation Center models, and this year, proposed several new services where the corresponding

[5] CMS Press Release, available at: https://www.cms.gov/newsroom/press-releases/inflation-reduction-act-continues-lower-out-pocket-prescription-drug-costs-drugs-price-increases-0.
[6] Seshamani M, Jacobs DB. Leveraging Medicare to Advance Health Equity. JAMA. 2022 May 10;327(18):1757-1758.

coding and payment would better acknowledge the resources needed to care for underserved populations. This includes highlighting the importance of addressing unmet health related social needs that can potentially interfere with the diagnosis and treatment of medical problems.

For example, CMS proposed separate coding and payment for community health integration services such as person-centered planning, health system coordination, and promoting patient self-advocacy. These proposed services were designed to include care involving community health workers, who link underserved communities with critical health care and social services in the community and expand equitable access to care, improving outcomes for the Medicare population. This work has been directly influenced by the advanced primary care and community-based transformational work of several CMS Innovation Center models including the Comprehensive Primary Care Model and the Accountable Health Communities Model.

Additionally, CMS proposed coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient. We also proposed to add the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment.

Payment For Behavioral Health and Treatment Services

For older Americans and individuals with disabilities enrolled in Medicare, many individuals have felt the effects of worsening depression and anxiety or have struggled with the use of substances like opioids or alcohol. Addressing these issues is critical to improving the health and

well-being of Medicare beneficiaries. To this end, CMS has proposed policies[7] that, if finalized, would create some of the most significant changes to promote access to behavioral health in the history of the Medicare program.

We know we need the help of every behavioral health practitioner to meet the behavioral health needs of every person with Medicare. Marriage and Family Therapists and Mental Health Counselors provide essential services, such as psychotherapy and group therapy – but to date, they could not enroll as Medicare providers. Following the enactment of the Consolidated Appropriations Act, 2023, CMS has proposed[8] procedures to allow marriage and family therapists and mental health counselors (including addiction counselors who meet all the requirements to be a mental health counselor) to enroll in Medicare in order to independently treat people with Medicare and be paid directly.

CMS is also working to close the gap in the types of behavioral health services covered by Medicare. Medicare has historically covered and will continue to cover services such as psychiatric hospitalization for people with acute psychiatric needs, partial hospitalization (a service that allows a patient to get inpatient hospital-level treatment during the day), and outpatient therapy. But sometimes patients need a more intense service than outpatient therapy, but less than the level of hospital-level care a hospitalization would provide – for example, a patient with debilitating depression, which causes them to struggle with daily tasks, but at the

[7] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/d/2023-14624; CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, available at: https://www.federalregister.gov/documents/2023/07/31/2023-14768/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

[8] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/d/2023-14624.

same time does not require hospitalization. Thanks to Congressional action, for the first time, CMS has proposed to pay for this intermediate level of care, called "Intensive Outpatient Programs", which can be performed by hospital outpatient departments, community mental health clinics, federally qualified health centers, or rural health clinics. For 2024, CMS has also proposed to: (1) provide payments for intensive outpatient services provided by opioid treatment programs[9]; (2) ease the required level of supervision for certain behavioral health services; and (3) more accurately value and pay for certain behavioral health services.[10]

When a person has significant psychological distress, crisis services may be necessary. Crisis services outside of clinical settings – where behavioral health practitioners meet patients in crisis where they are – can be especially important and effective. Through the implementation of legislation, CMS proposed to increase the value of psychotherapy for crisis services to pay 150% of the usual Physician Fee Schedule rate when this crisis care is provided outside of health care settings, which better reflects the costs that behavioral health practitioners incur to provide these services. CMS also proposed to increase the payment rate for substance use disorder treatment in order to better reflect the costs of the counseling services and to increase payment for psychotherapy services.

Payment For Telehealth Services

[9] CY 2024 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule, available at: https://www.federalregister.gov/d/2023-14768
[10] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

A report[11] from U.S. Department of Health and Human Services detailed a sixty-three-fold increase in traditional Medicare telehealth visits in 2020 to 52.7 million visits – a result of public health emergency waivers and new statutory authorities granted during the pandemic. These flexibilities helped maintain beneficiaries' access to care and supported providers' financial sustainability during the pandemic, when in-person visits declined dramatically. After Congressional action, Medicare permanently expanded access to telehealth for behavioral health services, including audio-only services for people who lacked access to or were unable to use video. We have proposed[12] to implement several telehealth-related provisions of the Consolidated Appropriations Act, 2023, including the temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home; the continued payment for telehealth services furnished by federally qualified health centers and rural health clinics; delaying the requirement for an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services; and the continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024. We know that telehealth services, both audiovisual and audio-only, 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.

[11] Samson LW, Tarazi W, Turrini G, Sheingold S. Medicare beneficiaries' use of telehealth in 2020: trends by beneficiary characteristics and location: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation; December 2021.
[12] CY 2024 Physician Fee Schedule Proposed Rule, available at: https://www.federalregister.gov/documents/2023/08/07/2023-14624/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other.

Engaging Our Partners and The Communities We Serve

All of this work has a common theme: we must work with our partners to put people with Medicare at the center of all that we do. We have heard from numerous stakeholders about their perspectives on where we can work together to drive meaningful change in the health care system. We want to hear ideas from our stakeholders and Congress on how we can advance health equity, expand access, drive high-quality, person-centered care, and promote affordability and sustainability in the Medicare program. We know that doing so requires deep collaboration across the many sectors that touch peoples' lives. We are committed to ensuring we integrate the perspectives of the communities that Medicare serves, as well as the providers and health plans that deliver health care, into our policies. Medicare is the bedrock of our nation's health system and wields tremendous influence on how our health system operates. Achieving our goals in Medicare will have an outsize influence on the rest of our health system and we look forward to working with you to improve the program.