U.S. House of Representatives
Committee on Small Business

"Stifling Innovation: Examining the Impacts of Regulatory Burdens on Small Businesses in Healthcare"

May 8, 2024

Statement for the Record
American Academy of Dermatology Association

Chairman Williams and Ranking Member Velazquez, on behalf of the American Academy of Dermatology Association (Academy) and its more than 17,000 U.S. members, thank you for the opportunity to submit a statement for the record for the Committee's hearing entitled *"Stifling Innovation: Examining the Impacts of Regulatory Burdens on Small Businesses in Healthcare"*

The Academy is committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of skin disease. As of 2023, 57% of dermatologists reported working in a dermatologist-owned practice, and 17% work as solo practitioners. Burdensome regulatory policies in the health care space can be damaging to small physician practices.

The Academy applauds the Committee for its efforts to examine policies that not only detrimentally impact small physician practices, but limit patients' ability to receive innovative and timely treatments. In dermatology, drugs and other therapies are frequently delayed or denied due to unnecessary prior authorization and step therapy policies. These

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overburdensome policies require tedious amounts of time to complete, often requiring multiple staff to oversee, taking time away from the practices' ability to focus on patient care.

As you explore ways to reduce regulatory burdens on small practices, one critical aspect that needs immediate attention is the instability of the Medicare physician payment system and the need for reform. The AADA firmly believes that Congress must take action to advance Medicare physician payment reform by:

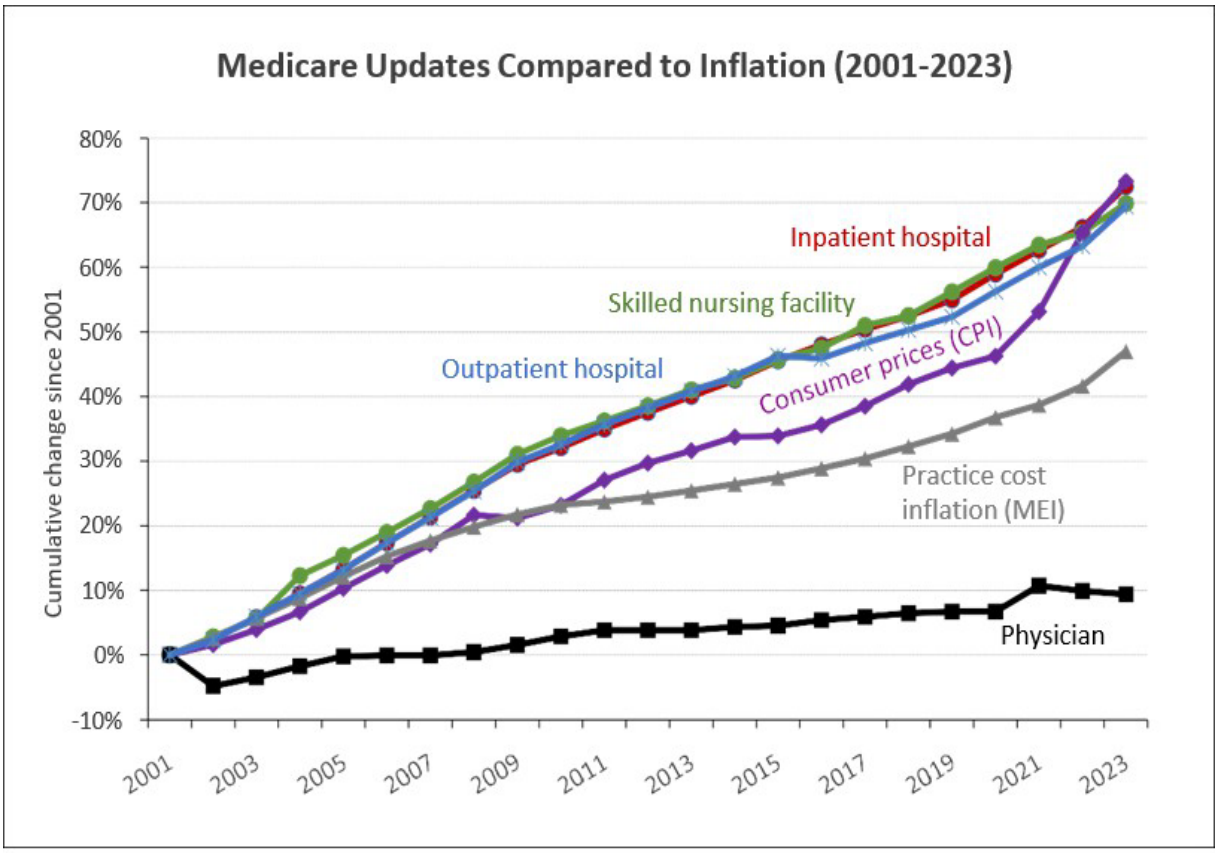
- Establishing a positive annual inflation adjustment.
- Increasing the budget neutrality threshold, supporting a lookback period to rectify errors associated with utilization assumptions, and allowing specific services to be excluded from budget neutrality requirements.
- Reforming the Quality Payment Program (QPP) to increase physician input and improve patient care without overly burdensome documentation and compliance activity.

In addition to these reforms, it's important to emphasize that Americans should have access to affordable, high-quality dermatologic care with the freedom to choose their own physicians and health insurance that best meets their needs. The Medicare program must ensure beneficiaries have adequate access to networks of specialists and subspecialists, including board-certified dermatologists. This goal can only be possible when health care policy is driven by the welfare of patients over short-sighted and siloed budgetary policies that increase overall health care spending and further erode the stability and predictability of the Medicare system.

Inflation and the Siloed Medicare Program Structure

The failure of the Medicare Physician Fee Schedule (MPFS) to keep up with inflation is the greatest threat to maintaining seniors' timely access to care in physician offices. Hospitals and other healthcare facilities receive Medicare payment updates, but physicians receiving payments under the MPFS are excluded from this type of adjustment. In fact, CMS finalized a 3.4% cut in the Calendar Year (CY) 2024 MPFS final rule. While the AADA appreciates the partial relief Congress provided to the MPFS in the Consolidated Appropriations Act, 2024, physician payments still ultimately received a cut from 2023.

Since 2001, the cost of operating a medical practice has increased 47%. During this time, Medicare hospital and nursing facility updates resulted in a roughly 70% increase in payments to these entities, significantly outpacing physician reimbursement. *Adjusted for inflation in practice costs, Medicare physician reimbursement declined 30% from 2001 to 2024.* This out-of-balance payment structure disproportionately threatens the viability of medical practices, especially smaller, independent, physician-owned practices, as well as those serving low-income or historically marginalized patients. This issue is further exacerbated by rising costs and inflation, leading to increased consolidation and hospital ownership of physician practices, resulting in higher expenses and reduced competition.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Congress and CMS need to re-examine the siloed approach to reimbursement tied to the Medicare program. According to the 2020 and 2021 Medicare Trustees' report, MPFS spending per enrollee was $2,107 in 2011 and $2,389 in 2021, growing at an average annual rate of 1.3%. However, in contrast, Medicare spending per enrollee in Part A fee-for-service (FFS) was $5,178 in 2011 and $5,576 in 2021 – a 7.7% increase and more than double the cost per patient treated under the MPFS.

In considering the failure of the MPFS to keep up with the rising costs of delivering medical care, it is important to remember that physicians rely on reimbursement to cover a multitude of practice expenses. These expenses include staff salaries, benefits, federal and state regulatory compliance costs, and expenses associated with insurance mandates, such as step therapy and prior authorization. Moreover, technology requirements associated with compliance of the QPP are costly and contribute to the financial strain placed on physician offices.

Physician practices are often small businesses that contribute to the economy of their communities. Other industries can adjust their products' pricing to reflect rising costs and increased staff salaries. However, physicians do not have the ability to do this. In fact, in the face of crippling inflation the MPFS serves to destabilize practices with year-after-year cuts. Such a structure is unsustainable, and we must not expect physicians delivering essential medical care to Medicare beneficiaries and their communities to endure it. Many physicians have already had to close their doors, leave their communities, retire early, or leave the practice of medicine. The below chart demonstrates the staggering numbers of physicians

leaving the workforce, and this trend will continue as nearly 45% of physicians are older than age 55. The loss of experienced physicians is detrimental to patient outcomes and the young physicians who rely on them as a learning resource.[1]

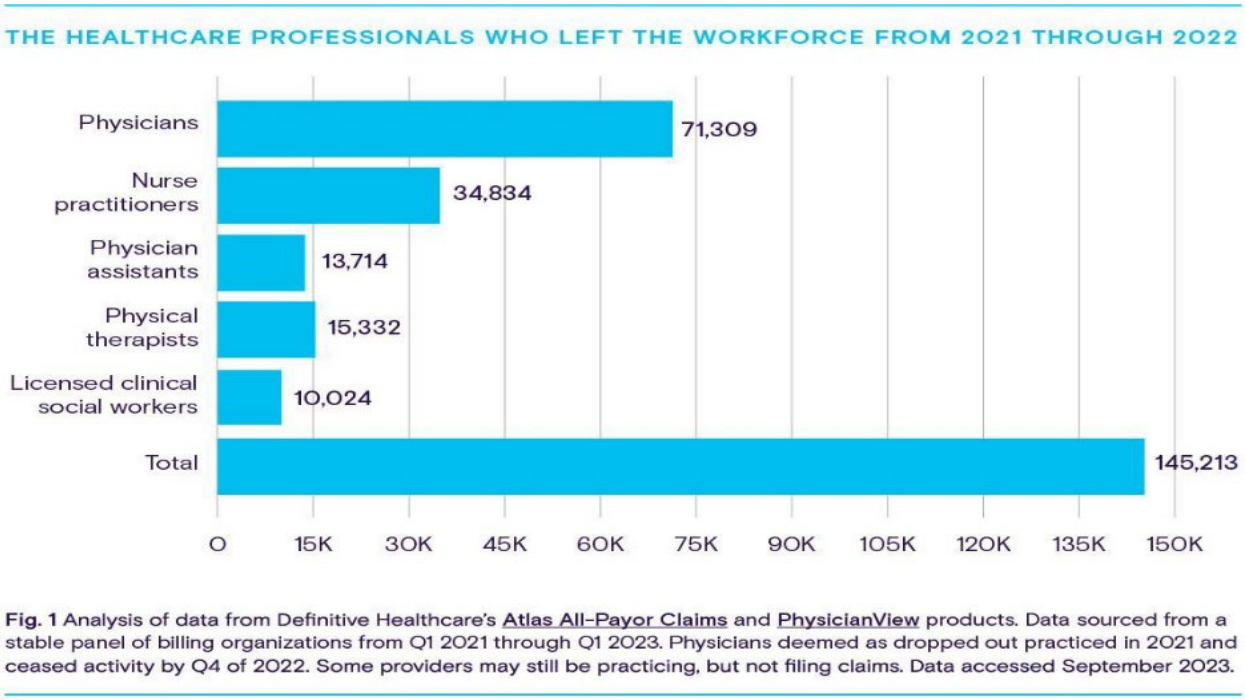


Fig. 1 Analysis of data from Definitive Healthcare's Atlas All-Payor Claims and PhysicianView products. Data sourced from a stable panel of billing organizations from Q1 2021 through Q1 2023. Physicians deemed as dropped out practiced in 2021 and ceased activity by Q4 of 2022. Some providers may still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

The inability to provide inflationary pay raises to practice employees is contributing to the current healthcare workforce crisis in which we are seeing increasing burnout rates and a mass exodus of our clinical, administrative, and clerical staff into other industries. With reduced staff comes a diminished capacity to provide quality care and maintain patient access. Reduced staffing leads to barriers in communicating and coordinating care, such as scheduling appointments and discussing lab reports, which can impact patient satisfaction and outcomes.

The threat of future additional cuts to Medicare physician reimbursement jeopardizes physicians' ability to keep the doors open and care for patients in our communities. Fewer physicians in our communities means longer wait times for patients to receive care. When those patients do receive care, their only option may be non-physician providers of care with less training, or more expensive care in sub optimal settings including emergency departments and hospital-based practices. This is real, not theoretical, and is already occurring in our communities. Medicare patients will suffer in the end with delayed and second-rate care at a higher cost.

Physicians need positive, inflation-based reimbursement updates to maintain financial stability and ensure patients have continued access to care. Inflationary updates tied to the Medicare Economic Index (MEI) need to be based on current data. In fact, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress tie physician payment updates to the Medicare Economic Index (MEI) or

[1] https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the-healthcare-staffing-shortage-2023.pdf

practice cost inflation rates for 2025.[2] Specifically, MedPAC recommended that Congress update the 2024 Medicare base payment rate for physician and other health professional services by the amount specified in current law plus 50% of the projected increase in the MEI. Based on CMS's MEI projections at the time of the publication of the March 2024 MedPAC Report to Congress, the recommended update for 2025 would be equivalent to 1.3% above current law.

The AADA appreciates MedPAC's acknowledgment that the current Medicare physician payment system has not kept up with the cost of practicing medicine. While we value this recognition, Congress should adopt a 2025 Medicare payment update that fully acknowledges the inflationary growth of health care costs. This step is crucial for ensuring financial stability in the Medicare physician payment system and maintaining continued access to high-quality patient care.

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

Budget Neutrality

Downward pressure on Medicare reimbursement is due to budget neutrality requirements, and has thus resulted in a decline of 30% in reimbursement since 2001. The Medicare statute requires that changes made to fee schedule payments be implemented in a budget-neutral manner.

Furthermore, by law, CMS must also create utilization assumptions for newly introduced services. When an overestimation occurs, it remains uncorrectable, leading to irreversible reductions in the funding allocated to the Medicare physician payment pool. For example, in 2013, transitional care management services were added to the MPFS. While CMS estimated 5.6 million new claims, actual utilization was under 300,000 for the first year and less than a million claims after three years. This overestimation led to a $5.2 billion reduction in Medicare physician payments from 2013 to 2021. This example highlights the unintended consequences of the current budget policies within the flawed system. We firmly believe that CMS should have the authority to rectify utilization assumption errors that impact budget neutrality.

In the absence of eliminating budget neutrality policy, we encourage Congress to pass H.R. 6371, the Provider Reimbursement Stability Act, to revise the budget neutrality policies to: (a) prevent erroneous utilization estimates from leading to inappropriate cuts; (b) clarify the types of services subject to budget neutrality adjustments; and (c) update the projected expenditure threshold triggering the budget neutrality adjustment, which has remained unchanged since 1992.

Reform Quality Payment Program

Value-Based Models

Current value-based programs are burdensome, have not demonstrated improved care, and are not clinically relevant to the physician or the patient, and we have serious concerns with the viability and effectiveness of the Merit-based Incentive Payment System (MIPS) program. Numerous studies have

[2] https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/

highlighted persistent challenges associated with MIPS, including practices serving high-risk patients and those that are small or in rural areas. A study titled "Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk," examined whether MIPS disproportionately penalized surgeons who care for patients at high social risk. This study found a connection between caring for high social risk patients, lower MIPS scores, and a higher likelihood of facing negative payment adjustments.[3]

Additionally, the Government Accountability Office (GAO) was tasked with reviewing several aspects concerning small and rural practices in relation to Medicare payment incentive programs, including MIPS. The GAO's findings indicated that physician practices with 15 or fewer providers, whether located in rural or non-rural areas, had a higher likelihood of receiving negative payment adjustments in Medicare incentive programs compared to larger practices.[4]

These studies highlight flaws in traditional MIPS, particularly in terms of potential disparities in care and the financial burdens placed on physicians when caring for high-risk patient populations and physicians in small practices. **The AADA recommends that Congress establish incentives, funding, and flexibility for physician offices with targeting small and solo practices.**

MIPS Value Pathways

Since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), CMS routinely introduces new changes to MIPS, requiring physicians to adjust continuously. Physicians are increasingly frustrated by the frequent modifications to the Quality Payment Program (QPP), including the associated administrative burdens of adhering to new program requirements and the lack of incentive payments to adequately compensate for participation efforts. While the AADA acknowledges CMS' attempt to address some of these concerns by introducing MIPS Value Pathways (MVPs) aimed at creating more meaningful groups of measures and activities to offer a more comprehensive assessment of quality of care, this new reporting option is falling short of achieving the Agency's goal.

The AADA has significant concerns with the Agency's approach to constructing MVPs, as it is using excessively broad measure sets that lack alignment and provide no added benefit in terms of enhancing patient care or helping patients determine the value of the clinician managing their care. CMS' approach fails to account for the realities of clinical practice and adds yet another layer of complexity to an already confusing program. Take for example, CMS' candidate MVP for Dermatological Care. Despite nearly two years of discussions and meetings between CMS and the AADA, CMS continues to express interest in the use of a single MVP for dermatology. This decision ignores the critical problem of a one-size-fits-all approach, as it cannot effectively compare costs and quality of care. We have shared with CMS that each subspecialty within dermatology provides unique services to distinct patient populations with varying practice patterns. This diversity in the practice of dermatology makes a one-size-fits-all model ineffective

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[3] Byrd JN, Chung KC. Evaluation of the Merit-Based Incentive Payment System and Surgeons Caring for Patients at High Social Risk. JAMA Surg. 2021;156(11):1018-1024. doi:10.1001/jamasurg.2021.3746.

[4] Medicare Small and Rural Practices' Experiences in Previous Programs and Expected Performance in the Merit-Based Incentive Payment System Report to Congressional Requesters United States Government Accountability Office.; 2018. https://www.gao.gov/assets/gao-18-428.pdf.

for comparing the cost and quality of care. For instance, dermatologists who treat psoriasis, which is currently considered in the candidate MVP's quality measures may not treat melanoma, which is currently the only measure related to cost available in the candidate MVP. Regardless of how CMS ultimately scores MVP participants, if CMS finalizes an MVP that includes a cost measure for a cancer-related disease and quality measures for an inflammatory skin disease, patients and clinicians will question its purpose and the extent to which it fails to drive value-based care.

Due to these numerous concerns, the AADA calls on Congress to urge CMS pause on moving forward with the MVPs. The AADA welcomes the opportunity to continue working with CMS and the Congress to identify opportunities to improve quality, patient outcomes, and efficiencies.

Burden on Physician Practices

Furthermore, the QPP must keep a keen focus on preventing physician and staff burnout based on the Department of Health and Human Services (HHS)[5] own priorities. This includes providing relief from systems-level factors that contribute to healthcare worker burnout by instituting measures that:

- Implement systems changes that reduce administrative paperwork overall.
- Facilitate coordination at the systems level without adding administrative burden to healthcare practices and healthcare workers.
- Provide funds to purchase human-centered technology that facilitates providing value-based care; and
- Ensure engagement in value-based care does not lead to additional workload, overhead, and work hours for specialists.

Conclusion

On behalf of the AADA and its member dermatologists, thank you for holding this hearing, allowing the opportunity for stakeholders to submit a statement for the record, and for your commitment to ensuring physicians can continue to serve their Medicare patients. The AADA looks forward to working with you and asks that you continue to consider including physician stakeholders' opinions in your ongoing hearings. Should you have any questions, please contact Jennifer Mangone at jmangone@aad.org.

[5] https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf