Alliance of Specialty Medicine

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Statement for the Record

House Energy and Commerce Committee
Subcommittee on Health Hearing:

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

October 19, 2023

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

Access Implications of Medicare Physician Fee Schedule Reimbursement Volatility

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

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

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

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

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

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

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

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

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

Solutions

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

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

Specialist Engagement in the Quality Payment Program

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

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

Because of these issues, many physicians struggle to find relevancy in the program and keep up with the cost of compliance. Recent research confirms the existence of these issues with MIPS, which have long been known to physician societies from members participating in the program. A 2021 study found that compliance with MIPS costs $12,811 per physician per year and that physicians and other clinical and administrative staff spend over 200 hours per physician per year on MIPS-related activities physicians.[5] The same year, the Government Accountability Office issued a report expressing concerns that MIPS performance feedback is neither timely nor meaningful, questioned whether the program helps improve quality and patient outcomes and highlighted the program's low return on investment.[6]

Untapped Resource: Clinical Data Registries

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

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

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

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

Advanced Alternative Payment Model Track

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

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

Regulatory Burdens in QPP

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

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

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

Solutions

The Alliance urges Congress to work with CMS to:

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

Administrative Barriers to Care

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

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

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

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

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

Solutions

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

Conclusion

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

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

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