AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

June 22, 2023

The Honorable Morgan Griffith
Chairman
Subcommittee on Oversight and Investigations
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kathy Castor
Ranking Member
Subcommittee on Oversight and Investigations
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member Castor,

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), thank you for holding today's hearing, entitled "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors." As the oldest medical and surgical specialty in the U.S., we are eager to share our perspective on how to fix the broken Medicare physician payment system and improve patients' access to care.

Founded in 1896, the AAO-HNS is the national medical association of physicians dedicated to the care of patients with disorders of the ears, nose, and throat, as well as related structures of the head and neck. The Academy has approximately 13,000 members who provide clinical, surgical, and hospital care in rural, urban, and suburban communities. Our membership spans academic, private independent practices, and employed physicians across all practice sizes - from solo to large, single-specialty and multispecialty groups reaching into the hundreds. Otolaryngologist–head and neck surgeons diagnose and treat patients from conception to end of life, providing complete diagnostic, medical, and surgical treatment for a wide range of medical conditions, including allergic and sinus disease, hearing and balance disorders, head and neck cancer, sleep disorders, speech and swallowing problems, cosmetic reconstructive surgery of the face and neck, acute trauma to the head and neck, and pediatric and geriatric care.

The Academy shares the Committee's desire to work toward a more affordable, sustainable, and patient-centered healthcare system. Healthcare reform is a complex problem, and there is no one-size-fits-all solution. We believe our specialty is in a unique position to see the challenges and varied and complex interactions that lay ahead – particularly given the relatively even split of medical and surgical management of diseases affecting the entire lifespan of our patients. As such, we share the following recommendations for your consideration.

Ensuring Equitable Physician Reimbursement

Medicare reimbursement rates have failed to keep pace with inflation and physician services have been perennial targets for cuts - payments are further eroded by Medicare budget neutrality rules require that any significant increases to Medicare payments for Part B services be offset by reductions elsewhere in the fee schedule. In fact, from 2001 to 2023, Medicare physician payment has effectively been cut by 26 percent, when adjusted for inflation. With rapidly increasing practice costs, widespread healthcare workforce shortages, and growing inflationary pressures, this

T: 1-703-836-4444
F: 1-703-833-5100
W: www.entnet.org
A: 1650 Diagonal Road, Alexandria, VA 22314

trend is not sustainable. It is no surprise that one in five physicians are considering leaving their practice within two years due to the stress of running a medical practice, including increased financial pressures and administrative burden.[1] Without legislative intervention, budget neutrality adjustments and the lack of inflation-adjusted payments will continue to erode physician payment.

Recognizing the need to act on this issue, in March, the Medicare Payment Advisory Commission (MedPAC) recommended for the first time that Congress tie physician payment levels to the Medicare Economic Index, which measures inflation in practice costs. Bipartisan legislation already introduced in the U.S. House of Representatives would act upon this recommendation. Led by Representatives Raul Ruiz, MD (D-CA), Larry Bucshon, MD (R-IN), Ami Bera, MD (D-CA), and Mariannette Miller-Meeks, MD (R-IA), the *Strengthening Medicare for Patients and Providers Act* (H.R. 2474) would tie annual updates to the Medicare physician fee schedule to the Medicare Economic Index. **Passage of the *Strengthening Medicare for Patients and Providers Act* is an important first step in providing much-needed financial stability for physician practices.**

Increasing Participation in Value-Based Care Models

Since its inception in 2015 the Medicare Access and CHIP Reauthorization Act (MACRA) has failed to improve patient care and lower healthcare costs. Under the Merit-Based Incentive Payment System (MIPS), most quality measures used do not follow the standard practice patterns of specialty physicians, nor have they proven to improve patient outcomes. The only consistent quality of the MIPS program is that it gets more difficult and expensive by the year for physicians, especially those in independent practice, to comply with the cadre of rules promulgated annually. To date, the highest incentive payment has been +2.33 percent, an insignificant amount when factoring in the administrative costs associated with participating in the MIPS program.

Specialists, particularly surgeons, have not been able to identify Alternative Payment Model programs they can successfully participate in to earn the five percent bonus. **It is important to maintain Qualified Clinical Data Registries (QCDRs) as an anchor to the current MIPS and any forthcoming Medicare quality improvement program.** These registries, such as the AAO-HNS' Reg-ent registry, can adequately recognize and incentivize high-quality care as well as identify areas for clinical improvement and cost savings.

Our specialty is engaged in defining quality for diagnosis and treatment of otolaryngologic disease using Clinical Practice Guidelines and a Clinical Data Registry that also works to improve outcomes, eliminate unnecessary care, and decrease costs. **In policy discussions surrounding the re-imagination of more equitable, value-based systems, it is essential to allow some flexibility through pilot studies to gather data on the value of each of these pilots before committing to one solution.** As we have learned through MACRA, there may not be one system that equitably fits all.

[1] https://www.mcpiqojournal.org/article/S2542-4548(21)00126-0/fulltext

T: 1-703-836-4444
F: 1-703-833-5100
W: www.entnet.org
A: 1650 Diagonal Road, Alexandria, VA 22314

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY®

Providing Adequate Reimbursement in Value-Based Models

A true value-based, quality program under Medicare should relate to the day-to-day practice of medicine and measure outcomes that are important to both physicians and their patients, not administrative markers. To increase participation in MACRA or a successor program, one must also consider economic principles.

Providers must be compensated appropriately, and the administrative costs and complexity must not dissuade participation. In terms of appropriate compensation, physicians must be treated equally to other Medicare providers and, at a minimum, receive annual payment updates based on an inflation proxy such as the Consumer Price Index (CPI).

In developing new measures of value-based care, Congress should direct CMS to work with each medical specialty society to develop best-care paradigms for the most common diseases/problems seen by each specialty. These paradigms will serve as the underlying foundation for value-based care and allow for well-defined cost and quality alignment modeling. Performance feedback based on these best-care paradigms will enable physicians to compare themselves to their peer group and help facilitate care improvement solutions. In addition, value-based care measures should not be limited to claims data but should incorporate patient-reported outcomes. The data is there, and it should be incorporated.

Transitioning Care from High to Low-Cost Facilities

A reliable cost-reduction strategy currently available to CMS is the transition of care from high to low-cost facilities when clinically appropriate. Our specialty can shift specific care away from hospital outpatient departments and into lower-cost ambulatory surgical centers and physician offices. However, CMS has failed to properly update the Medicare payment schedules to allow for this transition. **To enable care in lower-cost facilities, CMS must provide appropriate reimbursement on both the physician work and practice expense portion for these services.** This includes accounting for the overhead costs incurred by the provider. While this initially increases rates to the provider, it creates much greater savings to Medicare by avoiding the higher hospital outpatient fees.

The AAO-HNS appreciates the Committee's interest in developing a more affordable, sustainable, and patient-centered healthcare system. The policy recommendations provided in this letter are part of a larger subset that the Academy has to offer. We look forward to working together with you on this shared goal and offer ourselves as a resource for further discussions. If you have questions, please contact John Aguilar, Director of Advocacy, at jaguilar@entnet.org.

Sincerely,

James C. Denneny III, MD
Executive Vice President and CEO

T: 1-703-836-4444
F: 1-703-833-5100
W: www.entnet.org
A: 1650 Diagonal Road, Alexandria, VA 22314