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*Submitted to:* [hbc.health@mail.house.gov](mailto:hbc.health@mail.house.gov)

**Re: Request for Information: Examining Key Drivers of Health Care Costs to  
The Federal Budget and Proposals to Improve Outcomes While Reducing  
Health Care Spending**

Dear Representatives Burgess, Carter, Ferguson, Moore, Smucker, and Yakym:

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), I am pleased to submit the following response to your request for information (RFI) seeking solutions to improve patient outcomes and reduce health spending. The AAO-HNS is the largest 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 14,000 members worldwide 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 multi-specialty 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.

Healthcare reform is a complex problem, and there is no one-size-fits-all solution. The AAO-HNS shares your desire to work toward a more affordable, sustainable, and patient-centered healthcare system and applauds your efforts to seek input from clinicians to develop solutions. We believe our specialty is in a unique position to

understand the challenges and varied and complex interactions that lay ahead; we are proud to be a resource and a willing participant in this undertaking, given our relatively even split of medical and surgical management of diseases affecting the entire lifespan of patients.

**1) Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending.**

Administrative burden, which often takes the form of prior authorization and step therapy protocols, has emerged as a significant hurdle within the healthcare system, exerting a profound impact on both physicians and patients. One of the most palpable repercussions of high administrative burden is its contribution to escalating healthcare costs. Physicians are burdened with the arduous task of navigating complex administrative processes which vary considerably by payer, often spending valuable time seeking approval for prescribed treatments. This bureaucratic process not only consumes precious hours but also necessitates additional staffing and resources, all of which inevitably trickle down to the patients in the form of elevated healthcare expenses. In this sense, the administrative burden of prior authorization acts as an indirect tax on the healthcare system, exacerbating the already soaring costs of medical care and most importantly delaying timely access to care for patients.

Moreover, the weight of this administrative burden takes a toll on physician well-being and contributes to the escalating rates of burnout within the profession. The constant struggle to obtain approvals for necessary treatments can lead to heightened stress levels, frustration, and a sense of powerlessness among physicians. In a 2022 physician [survey](#) conducted by the American Medical Association (AMA), respondents indicated that they and their staff spend almost an average of two business days per week on prior authorizations. Eighty-eight percent of physicians describe the burden of prior authorizations as extremely high. This pervasive burnout not only jeopardizes the mental and physical health of physicians and their staffs, but also erodes the quality of care they can provide.

Ultimately, the consequences of prior authorization and step therapy protocols are felt most acutely by patients, as these administrative hurdles can lead to worse health outcomes. In that same AMA survey, one-third (33%) of physician respondents said that prior authorization led to a serious adverse event, such as hospitalization, disability, permanent bodily damage, or death, for a patient in their care. Eighty percent said these requirements can at least sometimes lead to patients abandoning treatments. It is imperative that we address and reform these administrative practices to alleviate the burdens placed on physicians and, most importantly, to prioritize the health and well-being of patients.

The AAO-HNS supports several legislative proposals that attempt to address these issues. The first is the “Improving Seniors Timely Access to Care Act,” which was included as part of the Health Care Price Transparency Act of 2023 and advanced by

the House Ways & Means Committee in July. This bill would modernize the antiquated prior authorization process in Medicare Advantage, which often still requires faxing documents to insurance companies. The bill would establish an electronic prior authorization process, require the U.S. Department of Health & Human Services (HHS) to establish a process for “real-time decisions” for items and services that are routinely approved, improve transparency by requiring Medicare Advantage plans to report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals or denials, and encourage plans to adopt prior authorization programs that adhere to evidence-based medical guidelines in consultation with physicians.

In the 117th Congress, this bill passed the House by unanimous consent. However, it did not pass the Senate. As we await a vote on the bill on the House floor, the Centers for Medicare & Medicaid Services (CMS) has put forward a proposed rule that closely mirrors this legislation. The AAO-HNS applauds CMS for taking steps to address administrative burden and prior authorization under Medicare Advantage and calls for this proposed rule to be finalized as soon as possible. Regardless of the related regulatory progress, we continue to urge Congress to take action, reintroduce the bipartisan bill in the Senate, and for passage in both chambers.

Regarding step therapy, the AAO-HNS strongly supports H.R. 2630 the “Safe Step Act.” This bipartisan bill would require group health plans to provide an exception process for any medication step therapy protocol to help ensure that patients can safely and efficiently access treatment. Step therapy hinders patients' access to care by mandating that they first try alternative treatments before being allowed access to more specialized options, even if the latter may be the most effective or medically appropriate choice for their condition. This process can lead to delays in receiving the necessary treatment, potentially allowing the condition to worsen before patients can access the most appropriate care. H.R. 2630 does not ban step therapy, instead placing reasonable limits on its use and creating a clear process for patients and doctors to seek exceptions and accelerated approval, if necessary.

Another proposal that would help reduce administrative burden is the concept of “gold carding.” This framework would allow a physician to bypass prior authorization requirements for items and services, so long as 90% of the physicians' requests were approved in the preceding 12 months. A program like this would help ensure that physicians who are operating in good faith with insurance companies are rewarded and that their patients quickly receive the care they need. A bill introduced this Congress, H.R. 4968 the “GOLD CARD Act”, would create such a program under Medicare Advantage. The legislation is based on a similar law enacted in Texas that took effect in 2021.

The AAO-HNS also continues to be deeply alarmed about the growing financial instability of the Medicare physician payment system due to a confluence of fiscal uncertainties physician practices face related statutory payment cuts, lack of inflationary updates, and significant administrative barriers. The payment system

remains on an unsustainable path threatening beneficiaries' access to physicians. According to an AMA [analysis](#) of Medicare Trustees data, when adjusted for inflation, Medicare physician payment has effectively declined 26% from 2001 to 2023. The Medicare physician payment system lacks an adequate annual physician payment update, unlike those that apply to other Medicare provider payments. A continuing statutory freeze in annual Medicare physician payments is scheduled to last until 2026, when updates resume at a rate of 0.25% per year indefinitely, well below inflation rates.

This reality is leading to a slow, but steady, decline in physician participation in the Medicare program. These reductions have been primarily driven by the budget neutrality statute, which aims to balance increases in reimbursement for certain services with corresponding decreases for others. Unfortunately, this approach often leads to across-the-board cuts, particularly in areas critical for patient care. Additionally, the lack of an inflationary update exacerbates the problem, as it fails to keep pace with the rising costs of providing medical services. Consequently, physicians find themselves in a financially strained situation, struggling to maintain the quality of care while operating within increasingly constrained budgets. This has spurred a growing trend of physicians choosing to opt out of the Medicare program, which ultimately jeopardizes access to care for the elderly and vulnerable populations who rely heavily on this essential healthcare coverage.

For these reasons, the AAO-HNS strongly supports H.R. 2474 the “Strengthening Medicare for Patients and Providers Act.” This bill would tie annual Medicare Physicians Fee Schedule (MPFS) updates to the Medicare Economic Index (MEI). That means that the MPFS would receive an annual inflationary update to reflect the increase costs of medical practices. This would go a long way toward addressing the ongoing need to provide financial stability to physician practices, in order to preserve access to care for Medicare beneficiaries. It will also help physicians invest in their practices and implement new strategies to provide high-value care. In its March 2023 report, MedPAC recommended that Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index. While 50 percent would be a step in the right direction, the AAO-HNS strongly urges Congress to require CMS to update the MPFS via the full MEI.

A reliable cost-reduction strategy available to CMS is to transition care from high to low-cost facilities when clinically appropriate. Our specialty has been shifting specific procedures 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 fees. Accomplishing this will require Medicare Part

B to have a similar funding mechanism as Medicare Part A that allows the agency flexibility to move away from the budget-neutral requirement that has created the current situation. Such a change would allow Congress more time to work on solutions to Medicare sustainability, rather than introducing annual legislation to ensure physicians receive appropriate reimbursement for providing care to Medicare patients.

Finally, the deleterious effect of the Administration's No Surprises Act regulations have created a situation where the healthcare insurance industry answers to no one and has resulted in policies that have become more detrimental to physician's practices than the Medicare policies because of the huge volume differential. Their denial of care and barriers to providing "best care" have mushroomed following the regulatory stance that currently exists.

## **2) Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes.**

The Merit-based Incentive Payment System (MIPS), established by the Medicare Access and CHIP Reauthorization Act of 2015, is a program that was felt to have great promise when introduced. However, the program has failed in most ways to deliver either savings or improved care. In fact, the Centers for Medicare & Medicaid Innovation (CMMI), the agency responsible for overseeing and implementing MIPS, has actually increased federal spending between 2011 and 2020 and is projected to continue to do so through 2030, according to a recent Congressional Budget Office report. Further, the majority of quality measures used in MIPS do not follow standard practice patterns of specialist physicians and have not shown any tracking toward improved patient outcomes or defining "best care".

The only consistent quality of the MIPS program is that it becomes more difficult and expensive for physicians, especially those in independent practice, to comply with the cadre of rules promulgated annually. These rules have failed to progress toward the true measurement of patient outcomes. Also, while the maximum payment adjustment will be 8.25% next year, it is disappointing that the advertised positive update for previous years has at most been 2.33%, while physicians were still subject to the -9% cut if they did not comply.

Additionally, CMS needs to provide much more data and information to physicians, if they are to expect greater participation. For example, physicians do not know at the time they provide a service or at any point during the performance year how they are performing on any of these measures that collectively account for 30% of their total MIPS score. They do not know in advance which cost measures they will be measured on, which patients are attributed to them, and for what costs or services provided by other health professionals or facilities outside of their own practices they will be held accountable. Providers who fall short of these targets are penalized and receive negative payment adjustments. To date, the highest incentive payment

has been +2.33%, an insignificant amount when factoring in the administrative cost associated with participating in the MIPS program. The successor to MIPS, the MIPS Value Pathway (MVP) is saddled with the same faults that its predecessor MIPS contains. Specialists, particularly surgeons, have not been able, to date, to identify APM programs that they can successfully participate in to earn the 5% bonus.

It is also critically 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. CMS' clinical data registry approval process under MIPS program is complex and cumbersome, and the lack of accessible cost data inhibits progress toward true value-based care. As a result, physicians' ability to leverage their participation in these quality improvement efforts for MIPS and engage in continuous learning has been limited.

Similarly, Alternative Payment Models (APMs) are a key approach to achieving value-based care by providing incentive payments to deliver high-quality and cost-efficient care for a clinical condition, a care episode or a patient population. However, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. Despite the many stakeholder-developed APMs recommended by the Physician-Focused Payment Model Technical Advisory Committee, very few Medicare APMs have been adopted to help specialists improve care for patients with chronic diseases. Instead of keeping patients healthier and preventing hospitalizations, the CMMI-developed APMs have largely focused on services provided to patients after they have already been admitted to the hospital or begun treatment. As a result, APM incentive payments provided under MACRA to support physicians transitioning to APMs have reached far fewer physicians than had been forecast. In addition, MACRA requires increasing threshold percentages of APM participation for physicians to qualify for the APM incentive payments, but most APM participants cannot attain the higher thresholds.

It has become evident that changes are imminently needed to realize the robust pathway to APMs that Congress envisioned. These critical changes will help improve patient outcomes and reduce unnecessary Medicare spending, as well as help CMS reach its auspicious goal of having every Medicare patient in a value-based arrangement by 2030.

While CMS has tried to address these various issues, these changes are superficial as the agency is hamstrung by its lack of statutory authority to remedy these problems directly. Congress must step in and act to: prevent unsustainable penalties, particularly on small, rural and underserved practices; invest in and enable the move to value-based care; and increase transparency and oversight in the program.

The AAO-HNS does appreciate the inclusion of Quality Care for Treatment of Ear, Nose, and Throat Disorders as one of the newest MIPS Value Pathways (MVP), under this year's proposed MPFS. If finalized, this MVP will provide otolaryngologists an opportunity to participate in the MVP program for the first time. The AAO-HNS looks forward to further collaborating with CMS in the MVP maintenance and expansion process. The Academy will also continue to develop and submit additional otolaryngology-specific measures to cover the many subspecialists within otolaryngology to ensure the MVP is applicable to most of the specialty.

### **3) Comments on CBO's modeling capabilities on health care policies, including limitations or improvements to such analyses and processes.**

The Congressional Budget Office's (CBO) method of scoring health care bills falls short in accurately assessing the true long-term fiscal benefits of preventive health measures. These initiatives, while incurring a high initial cost, have the potential to yield substantial savings by averting more serious and costly ailments in the future. However, the CBO is constrained by its framework, which limits its assessment to a ten-year window post-enactment of a bill. This constraint fails to capture the comprehensive financial impact of preventive measures, as their benefits often extend well beyond this narrow timeframe.

Preventive health measures, such as early screening and intervention, and lifestyle modification programs, are invaluable in reducing the burden of chronic diseases and curbing healthcare expenditure in the long run. By identifying health issues at their nascent stages and providing timely interventions, these measures can significantly mitigate the progression of diseases, ultimately leading to reduced healthcare costs. Unfortunately, the CBO's scoring system is ill-equipped to account for these delayed savings, focusing primarily on immediate budgetary implications. This narrow lens limits the agency's ability to accurately project the broader fiscal advantages of preventive care.

Furthermore, the ten-year window constraint also overlooks the substantial societal benefits that arise from effective preventive measures. Improved public health leads to a more productive and economically active population, ultimately contributing to a stronger and more resilient economy. Additionally, the intangible gains in quality of life, reduced suffering, and enhanced well-being for individuals and families are incalculable, yet immensely valuable. Therefore, it is imperative to reevaluate the scoring methodology to ensure that the true value of preventive health measures is accurately reflected in the assessment of healthcare bills.

For these reasons, the AAO-HNS generally supports legislation that would address this issue. One such bill, H.R. 766 the "Preventive Health Savings Act", would require CBO to use dynamic scoring to assess the potential long-term savings of healthcare-related legislative proposals.

#### 4) Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long term health costs.

Much like other health conditions, addressing hearing loss in its early stages holds a pivotal role in preventing a cascade of more severe, costly health issues. Beyond the obvious communication challenges, untreated hearing loss has been linked to a range of debilitating consequences. Social isolation and loneliness often accompany hearing impairment, as individuals may withdraw from social interactions due to the difficulty in understanding conversations. This isolation, in turn, can lead to profound emotional effects, including depression and cognitive decline.

Furthermore, untreated hearing loss is closely associated with balance problems and an increased risk of falls. The auditory system plays a vital role in maintaining equilibrium, and when compromised, it can lead to a higher likelihood of stumbling or losing one's balance. This heightened risk of falls can result in injuries that have a lasting impact on a person's overall health. Additionally, studies have shown that hearing loss is connected to a range of systemic health concerns. Conditions like cardiovascular disease, diabetes, and even dementia have been found to have stronger links to untreated hearing loss. While the precise mechanisms are still being investigated, it underscores the systemic implications of this seemingly localized sensory deficit.

Early intervention for hearing loss is not only crucial for improved communication but also for the prevention of secondary health issues. By recognizing and addressing hearing impairment in its initial stages, individuals can take proactive steps to mitigate the potential for social isolation, depression, balance problems, and the associated risk of serious medical conditions. This underscores the importance of regular hearing assessments and timely intervention to safeguard both auditory and overall well-being.

#### Conclusion

The AAO-HNS greatly appreciates the opportunity to provide comments and recommendations toward the development of a more affordable, sustainable, and patient-centered healthcare system. The comments provided in this letter are that of a larger subset that the Academy has to offer. We look forward to working together in the 118th Congress on this shared goal and offer ourselves as a resource for further discussions.

Sincerely,



James C. Denny, III, MD  
Executive Vice President/CEO