AMERICAN ACADEMY OF
OTOLARYNGOLOGY–
HEAD AND NECK SURGERY®

June 14, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B

Dear Charman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), I am pleased to submit the following comments to the Senate Finance Committee's white paper on "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B."

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 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 healthcare providers to develop solutions. We believe our specialty is in a unique position to see 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.

<u>Reforming the Medicare Physician Fee Schedule</u>

The AAO-HNS continues to be deeply alarmed about the growing financial instability of the Medicare physician payment system due to a confluence of fiscal uncertainties including statutory payment cuts, a lack of inflationary updates, and

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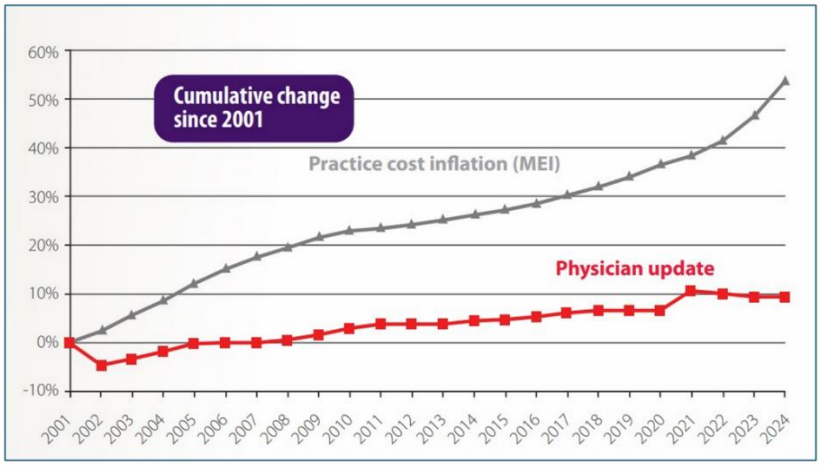
significant administrative barriers. The payment system remains on an unsustainable path threatening beneficiaries' access to physicians. According to an AMA analysis of Medicare Trustees data, when adjusted for inflation, Medicare physician payment has effectively declined 29% from 2001 to 2024.

Medicare updates compared to inflation in practice costs (2001-2024)



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

The Medicare physician payment system lacks an adequate annual inflationary 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 seniors and vulnerable populations who rely on this essential healthcare coverage. This is a very concerning trend as Medicare's enrollment is projected to increase to more than 80 million beneficiaries in 2030.

For these reasons, **the AAO-HNS strongly urges the adoption of an annual inflationary update for the Medicare Physician Fee Schedule (MPFS)**. In the House of Representatives**, the Academy supports H.R. 2474 the "*Strengthening Medicare for Patients and Providers Act.*"** This bill would tie annual MPFS updates

to the Medicare Economic Index (MEI) providing an annual inflationary update to reflect the increased costs of medical practice. Such an update would help physicians invest in their practices and implement new strategies to provide high-value care. In its latest report, MedPAC recommends that Congress should update the 2025 Medicare base payment rate for physician and other health professional services by 50% of the projected increase in the Medicare Economic Index. While 50% would be a step in the right direction, the AAO-HNS strongly urges Congress to require CMS to update the MPFS using the full MEI.

Changes also need to be made to the baseline policy of budget neutrality. While the Academy recognizes the need to include a mechanism to prevent exponential cost increases, there are ways to improve how this goal is achieved. **The AAO-HNS strongly supports a bill in the House of Representatives, H.R. 6371 *the Provider Reimbursement Stability Act,* which includes several provisions designed to address this problem**. First, the bill would increase the budget neutrality trigger threshold from $20 million to $53 million. This $20 million threshold was established in 1992 and has not been updated since. Increasing the threshold to $53 million would recognize inflation and allow for greater flexibility in making necessary pricing adjustments for individual services without triggering automatic, across-the-board Medicare cuts.

Second, the bill would provide a lookback period to reconcile overestimates and underestimates of pricing adjustments for individual services. This would allow for the MPFS conversion factor to be prospectively adjusted based on actual utilization data after a full year's worth of claims data becomes available. This would make a significant difference, as it is not uncommon for CMS to overestimate utilization in its budget neutrality estimates. The Committee's white paper included one of the most prominent examples of this phenomenon – the adoption of the Transitional Care Management Codes. Overestimates like this do not get corrected and physicians pay the price.

If this policy were adopted, it is also critical that CMS be directed to utilize a multitude of data sources. For example, the Academy is one of many physician organizations that has a Qualified Clinical Data Registry. The AAO-HNS' Reg-ent registry contains data which can facilitate improving outcomes, eliminating unnecessary care, and decreasing costs. This real world data demonstrates how our members practice medicine and can provide a much clearer picture of how the inclusion of new services may affect costs. Without using data taken directly from physicians in practice, CMS will be more likely to continue to make incorrect utilization estimates.

Third, the bill limits year-to-year conversion factor variance. The bill would limit positive or negative increases to the MPFS conversion factor to no greater than 2.5% each year. In 2024, physicians were scheduled to receive a cut upwards of 4.6% to the conversion factor. Congress stepped in to reduce the cut to 1.68%. Lastly, the bill would require the direct inputs for practice expense relative value units to be updated at least every five years.

Direct inputs include clinical wages, as well as prices of medical supplies and equipment, which are currently not reviewed or updated on an annual or regular basis. The lag in concurrent review with work RVUs has led to significant payment redistribution. This is also an important point for consideration in any systemic reform of the fee schedule, as the inclusion of new technology covered by Medicare has the same downward budgetary effect as including new services. Additional funding needs to be allocated to support practice advances and account for new items or technology.

Additionally, the cost attributed to items and technology is primarily based on company invoices for the purchase of such items. This in itself is a flawed methodology for calculating practice expenses. **At the very least, there needs to be a mandated, periodic review of practice expense inputs to ensure accuracy and necessity of the inputs.**

Integrity, Reliability, Accuracy in CMS's RVU and rate-setting processes

For over 30 years, the AMA Relative Value Scale Update Committee (RUC) has been in place to recommend code valuations to CMS. CMS ultimately has the authority to decide whether to accept or decline those recommendations. To maintain the integrity of the rate-setting processes we believe it is imperative that there be a level of transparency explaining this process. Currently, it is unclear what scenarios cause the agency to not accept the RUC recommendations and in turn how the value assigned to the code is determined. Because of this lack of transparency, the process feels arbitrary and inconsistent.

From 1992 until 2016 the CMS refinement panel was in place to hear and review any appeals in cases where CMS disagreed with the RUC recommendation. For many years, the percentages of codes that were published with values based on the refinement panel were greater than 75% and for many years close to 100%. The AAO-HNS feels that the refinement panel was a clear example of an appeals process to increase the transparency and information sharing from CMS related to code valuation. **The AAO-HNS urges CMS to reestablish the Refinement Panel process to create an objective, transparent, and consistently applied formal appeals process, that would be open to any commenting organization, and provide stakeholders with an avenue to appeal.**

The reintroduction of an appeals process or refinement panel process, coupled with the input from the AMA/Specialty Society RVS Update Committee (RUC), would provide the best mechanism to utilize the expertise from physicians and other health care professionals to determine the resources utilized in the provision of a service to a patient**.** As for the body hearing the appeals, this group should be comprised of knowledgeable experts in the field and should be elected in some way as opposed to appointed. To ensure the integrity of the process all parties must abide by the process and be accountable within the process (CMS, providers, and code

applicants.) **The AAO-HNS strongly believes that physician input is essential to identifying the valuation of physician services.**

Improving Alternative Payment Models (APMs) & Merit-Based Incentive Payment System (MIPS)

MACRA's Merit-based Incentive Payment System (MIPS) program was felt to have great promise as conceived, but the program has failed in most ways to deliver either savings or improved care. 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, the final measuring stick. 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.

The AAO-HNS recognizes that Alternative Payment Models (APMs) may provide 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, due to a lack of approved APMs that apply to specialty physicians, high initial costs of transitioning to an APM, and the looming end of the incentive payment, far fewer physicians participate in APMs than had been forecast.

Unfortunately, most of the APMs created by CMMI to date have been designed primarily to cut Medicare spending and shift financial risk to physicians and hospitals, not to give physicians the resources and flexibility they need to improve care for patients. A 2021 study by the Government Accountability Office found that physicians in rural and underserved communities faced particular challenges in participating in the APMs created by CMMI. However, the APMs available in 2024 have essentially the same structure as those available when that article and study were written.

When Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we were hopeful that this would result in the creation of better APMs that would help physicians deliver higher-quality care to their patients. Many frontline physicians who had experienced barriers to value-based care in their practices spent many hours to develop proposals for patient-centered APMs that could offer meaningful benefits to patients and savings for the Medicare program.[1] The PTAC ultimately recommended more than a dozen of these physician-designed, patient-centered APMs. However, **to date, not a single one of these models has been implemented or even tested by CMMI.** Two leading members of the PTAC resigned several years ago, stating their belief CMS had no intention of ever implementing any APM recommended by PTAC.

[1] See examples at https://www.ama-assn.org/practice-management/payment-delivery-models/medicare-alternative-payment-models.

We therefore offer the following recommendations for the Committee's consideration:

- 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 by measuring outcomes they are trying to achieve, not administrative markers. **To increase participation in MACRA or a successor program, one must also consider economic principles. Physicians 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, CMS should 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 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.

- Regarding the thresholds for determining MIPS eligibility, the **AAO-HNS suggests returning to the original thresholds if the current QPP framework is to be maintained**. This adjustment would broaden clinician involvement. Presently, the participation criteria is restrictive, prohibiting the establishment of quality measure benchmarks as voluntary data is not considered into benchmark creation. Consequently, each year sees a reduction in benchmarked measures, heightening the challenge of meeting increasing performance thresholds. Although the program aimed to improve quality and cost effectiveness, it has failed to do so because of insufficient participation which disproportionately affects some specialties.

- To ensure a broader array of A-APM options, **CMS should allow medical specialties to try to pilot several options rather than just try one model**. Each medical specialty is going to need individualized design to meet the needs of their practice and their patients. The current framework does not allow for this flexibility, and thus limits participation from surgical specialties. Additionally, CMS should approve additional non-primary care ACOs. The current ACOs care for the most part limited to primary care, and thus limit potential participation from surgical specialists.

- To increase participation in A-APMs, there are a number of factors that should addressed to maximize physician participation: 1) removing barriers

to care such as prior authorization and other administrative tasks; 2) allowing flexibility to use bundling for medical services; 3) the ability to contract for the services you actually need based on your area of expertise or need; 4) the concept of an "à la carte" design so physicians get credit for working with an ACO; and 5) lowering the risk threshold would incentivize participation – particularly the smaller physician practices.

- Participating in data registries should continue, and expand, as a fundamental practice enhancement and incentive, enabling clinicians to monitor and compare their performance against national or regional benchmarks. **The AAO-HNS suggests broadening these incentives, as specialty society registries catalyze procedural enhancements, enhance patient outcomes, and propel healthcare progress through research.** Many specialty society registries feature supplementary measures and initiatives beyond governmental reporting, which significantly impact patient outcomes. Moreover, these registries extend comprehensive services for conducting research studies aimed at advancing healthcare.

  The existing program has fallen short in enhancing healthcare quality and reducing healthcare and program costs. Specialty society registries have had to channel their efforts towards comprehending and executing intricate program policies. This has further burdened practices with the task of meticulously checking boxes with limited reward. As a result, provider attention has been diverted from patient care. Redirecting efforts towards interoperability to contribute their clinical data to a research clinical data registry would alleviate practice and administrative burdens yet lead to advancements in health and patient care. **AAO-HNS advocates for recognizing this research collaboration to satisfy quality, improvement activity, and Promoting Interoperability performance categories to streamline programs costs and enhance healthcare outcomes.** This alternative method would enhance patient outcomes and promote value-based care by investigating optimal practices and utilizing advanced medical devices and treatment.

<u>Supporting the healthcare team to transform chronic disease care</u>

Physicians, including otolaryngologist-head and neck surgeons, and health systems across the country continue to face the growing challenge of preventing and managing chronic diseases. The Centers for Disease Control and Prevention estimates that 90% of all healthcare costs in the U.S. go toward treating chronic disease and mental health — about $3.7 trillion a year. This highlights the need to support and create innovative approaches, such as team-base care, to ensure patients with chronic disease have access to both medical and surgical care – particularly in rural and underserved areas. An example of an innovative approach is incentivizing regular visits for the chronically ill to ensure preventive screenings are occurring to reduce cost of care and ensure early interventions.

As the Committee considers changes to the current Medicare payment system, **flexibility in supporting the comprehensive physician-led healthcare team is essential to effectively managing the growing burden of chronic disease on the overall health system.**

Again, we thank the Senate Finance Committee for furthering the discussion to improve Medicare physician payment and increase patient access. The AAO-HNS stands ready to offer ourselves as a resource for further discussions. If you have any questions or require further information, please contact govtaffairs@entnet.org.

Sincerely,

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