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June 14th, 2024

The Honorable Ron Wyden
Chair
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC 20510

Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
239 Dirksen Senate Office Building
Washington, DC, 20510

Dear Chair Wyden and Ranking Member Crapo:

On behalf of the 8,500 American College of Rheumatology (ACR) members, I write to provide feedback on the important policies discussed in the Senate Finance Committee's white paper "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." The ACR welcomes the opportunity to comment on current challenges facing physicians providing care under Medicare Part B and to reiterate the policy solutions that could ensure that physicians can meet the needs of chronic disease patients in their communities.

Physician Payment Policy Challenges and Reform

The Center for Medicare and Medicaid Services (CMS) continues policies that systematically devalue reimbursements through the Medicare Physician Fee Schedule (MPFS), jeopardizing physicians' ability to serve Medicare patients and sustain viable medical practices. The growing divide between practice expense and MPFS payment, combined with the administrative and financial burden of participating in Medicare, incentivizes providers to limit the number of Medicare beneficiaries they can accept, or make the difficult choice not to accept Medicare patients and only accept cash or private insurance as payment for services. As physician-owned practices combat insecurity around varying payments from Medicare for treating patients, these patients' access to care is put at risk. This leaves the most vulnerable Americans, including seniors, the disabled, and those living in underserved communities disproportionately affected and with few options for medical care.

Without an annual payment update, the 2024 MPFS conversion factor is $32. 74, lower than it was in 2001. If the MPFS conversion factor were tied to inflation, it would be $67.39. At the same time, per-beneficiary spending has grown substantially faster than the Medicare Economic Index (MEI) or MPFS updates. Physicians are the only Medicare service providers whose payments are not currently linked to the MEI.

As a result, physician practices are never certain what the reimbursement rate will be each year. So, they squeeze more patients into the schedule daily to make up for the new cuts; leaving physicians and patients dissatisfied. The resulting physician burnout threatens the sustainability of medical care for all Americans.

For these reasons, the ACR urges the Committee to require CMS to provide an annual inflation-based payment update based on the full MEI.

The ACR agrees with a broad range of medical specialty organizations for implementation of a 100% inflationary update based on the MEI. The ACR commends MedPAC for making a 50% MEI based recommendation while understanding that this suggestion will not go far enough to meaningfully address MPFS payment and ensure stable access to care for millions of Medicare beneficiaries. This rationale only accounts for practice expense components of the fee schedule. However, payment for physician work—the time, energy, and expertise devoted to treating patients, also contributes to total practice expense, and is equally impacted by inflation. A rationale that half of MEI is sufficient because the practice expense component of physician payment accounts for approximately half of total Medicare physician payments reflects an incomplete picture.

Reform or Repeal Budget Neutrality Requirements for the Physician Fee Schedule

A provision included in the Omnibus Budget Reconciliation Act of 1989 mandated that any estimated increases of $20 million or more to the MPFS—created by upward payment adjustments or the addition of new procedures or services—must be offset by cuts elsewhere. Therefore, each time a code is reviewed and updated to reflect a reformed, higher value; the conversion factor is cut to offset that increase. While the conversion factor calculated by CMS varies by year, the $20 million budget neutrality threshold has never been increased by Congress. Budget neutrality places an artificial cap on the cost of care in the MPFS. While budget neutrality is unsustainable in the long term, immediate relief is obtainable through increasing the budget neutrality threshold while allowing for automatic MEI adjustments to the fee schedule. This increased flexibility will allow a more thoughtful valuation of Medicare procedures and services, without triggering cuts to all MPFS codes.

ACR supports raising the budget neutrality threshold from $20 million to $53 million, its original inflation-adjusted amount.

Finally, it is not uncommon for CMS to vastly overestimate utilization assumptions related to new services. As the Committee noted, the most prominent example occurred when transitional care management (TCM) services were added to the MPFS in 2013. CMS estimated that 5.6 million new claims would be submitted for these services. The actual utilization turned out to be under 300,000 claims for the first year and was still less than one million after three years. As a

result of this overestimation of TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021. Once these reductions to the conversion factor are made, they are never reinstated, even though actual utilization was far lower than projected.

In these circumstances is not budget neutrality, but rather permanent and unjustifiable Medicare cuts to physician payments across-the-board.

ACR recommends that Congress requires CMS to reconcile utilization assumptions with actual claims data, with CMS adjusting the CF as appropriate. Additionally, Congress should limit budget neutrality adjustments in any given year to 2.5%, so when changes cause large disruptions to the MPFS, they do not cause abrupt changes in CF calculations in any given year, providing further stability to physicians serving Medicare patients.

Policy requiring CMS to review direct input from claims and reconcile as needed on set timeline would address concerns raised by this committee and other stakeholders regarding inaccurate utilization assumptions triggering budget neutrality adjustments. Periodic review by CMS ensures that practice expense RVU's accurately accounts for the true cost of care and would allow CMS to maintain the integrity of data used to make valuations. Congressional action would also avert concerns of volatility resulting from solely regulatory changes.

Chronic Care in Medicare

The ACR agrees with the panelists who spoke at the committee's April 11th hearing, regarding chronic disease as the "most important challenge affecting Medicare beneficiaries and the Medicare Program." As the leading cause of disability reported by the CDC, arthritis impacts many of our nation's seniors. Data from the Chronic Condition Warehouse (CCW), as provided in the white paper, shows that Medicare beneficiaries with rheumatoid and osteoarthritis required the utilization of 34.6% of services and procedures by Medicare in 2021. This utilization rate was the third most prevalent on the 30 CCW, highlighting the scale at which Medicare beneficiaries are impacted by common forms of arthritis.

Cognitive Specialty Reimbursement:

Cognitive care like rheumatology involves face-to-face, non-procedural medical care in which physician specialists examine and counsel patients as they evaluate and manage the patient's conditions. Timely diagnosis and thoughtful management of rheumatic diseases allow patients to maintain quality of life while preventing disability and decreasing healthcare costs due to hospital visits and/or surgical interventions. The primary evaluation and management (E/M) codes often billed for rheumatologic care reflect specialized knowledge and decision-making and additional time required to treat complex, chronic diseases.

Cognitive care services have been historically undervalued. As observed by MedPAC, the structure of the MPFS prioritizes procedures at the expense of cognitive care. Codes that reimburse procedures are more often reviewed for the MPFS on a roughly five-to-seven-year cycle. The review of these codes necessitates upward adjustments in payment up to the statutory $20 million budget neutrality threshold. As a result, E/M codes are more frequently cut across the board to ensure cumulative valuation does not exceed this $20 million cap. In contrast to procedural codes. E/M codes do not have a set schedule for review.

ACR supports reforming the current MPFS system where reimbursement codes for procedures are reviewed more often than E/M codes perpetuating substantial compensation disparities at the expense of primary care physicians and cognitive specialties like rheumatology.

Recent regulatory action related to chronic disease management and the MPFS has offered support to Medicare physicians. A recent review of E/M codes for the first time in 30 years has brought more appropriate valuation, as the newly implemented G2211 code will provide payment for complex services as part of long-term care. G2211 more accurately captures the additional costs clinicians pay to deliver ongoing care to patients living with single, serious, or complex chronic diseases like rheumatic and musculoskeletal conditions. The ACR applauds CMS's implementation of this code to support vital chronic disease care in Medicare. Yet this recent bump does not undo years of damage from the passive devaluation of cognitive care.

Alternative Payment Models

In April 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) eliminated the Medicare payment system based on the Sustainable Growth Rate formula and implemented a transition period intended to incentivize payments based on value. 2024 is the eighth year of the Merit-Based Incentive Payment System (MIPS), which scores providers based on (1) Quality (based on PQRS), (2) Promoting Interoperability (formerly Advancing Care Information, and based on Meaningful Use), (3) Clinical Practice Improvement, and (4) Cost. Providers' performance on MIPS measures will provoke payment adjustments, in the form of bonuses or penalties two years after the reporting year unless providers join an Alternative Payment Model (APM).

In 2018, CMS implemented the resource use, or cost, category as a component of MIPS scoring. This is concerning as Part B drug costs are included in the cost component and count toward a practitioner's score, though Part D drug costs are not included. Under this system, rheumatologists may be penalized for providing medically necessary Part B drug treatments to their patients. The ACR supports new cost measures that are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently

discourage clinicians from caring for high-risk and medically complex patients. This will safeguard practitioners, especially specialists like Rheumatologists, where there is a higher use of necessary and effective yet expensive medications, like biologics.

Overall, the MACRA framework forces providers to choose between the uncertainty and financial risk of joining an APM and the possibility of overwhelming financial burdens from the MIPS system. A third option, the MIPS Value Pathway (MVP) has been instituted to help ease providers, especially the smaller groups and solo practitioners, from MIPS to APMs and began implementation in 2023. The initial reporting period is through 2025 and in 2026 multispecialty groups will be required to form subgroups. These three programs must allow for meaningful and streamlined quality measurement without placing an unnecessary burden on the provider. Practices may see fewer Medicare patients or opt out of Medicare altogether if they are not able to succeed under these programs. Patients could be left with longer wait times and travel distances or increased out-of-pocket costs.

Flexibility in the design of the MIPS and future MVPs and simplicity in implementation should drive the refinement of these programs. Participation in APMs would be improved by lowering payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM and by minimizing initial risks to which providers are exposed. Appropriate data and measurements should be used to develop these programs to ensure there are no biases against certain patients and their physicians.

<u>The ACR supports the following policies pertaining to APM's</u>:

- Appropriate management of MACRA and protecting access to rheumatologists and rheumatology interprofessional team members in these ways:
    - Use of metrics that are clinically relevant, efficient, and promote quality of rheumatologic care in the components of the Merit-Based Incentive Payment System (MIPS) and implementation of MIPS Values Pathways (MVPs).
    - Creating and giving proper accreditation to a variety of Alternative Payment Models and demonstration projects that recognize the value of care provided by rheumatologists and rheumatology interprofessional team members.
    - Counting participation in a Qualified Clinical Data Registry such as RISE toward MIPS participation under MACRA.
    - Transparency in MIPS, MVPs, and APMs, allowing practicing physicians to easily understand and implement these programs.
    - Improving transparency and accountability of the processes by which Medicare Administrative Contractors implement Local Coverage Determinations and ensure provider input on all new or revised policies.
- Maintaining appropriate reimbursement conversion factor for the work RVU's so that the change in the wRVU yields appropriate reimbursement to physicians as intended.

- Simplifying the MIPS and MVPs program through reduced reporting requirements and flexibility to account for practice variation.
- Continuing a minimum 90-day reporting period for MIPS domains of Promoting Interoperability and Improvement Activities.
- Streamlining reporting systems for each MIPS category.
- Ensuring that providers who participate in a Qualified Clinical Data Registry (QCDR), can maximize credit in MIPS for doing so.
- Policy encouraging smaller practices to participate in APMs by lowering the payment amount and patient count thresholds required to achieve qualifying participant status in an advanced APM, and by minimizing initial risks to which providers are exposed.
- Policy ensuring new payment models include only those quality measures that are meaningful to patients and simple for providers to implement.
- Implementing efficient evidence-based performance measures that improve the quality of care and promote fair reimbursement for work done by rheumatologists and rheumatology interpersonal team members in collecting and reporting administrative data.

Telehealth

Data collected during COVID-19 demonstrates the positive impact telehealth has had on both patient clinical outcomes and patient experiences. A study by the National Institutes of Health (NIH) found telemedicine to be beneficial in both acute care and chronic disease management. Results from the study suggest that it is equivalent to in-person care for health outcomes in certain conditions and may also decrease short-term hospital and emergency department utilization. Additionally, research shows that the use of telehealth provides access to care despite geographic barriers, reduces the burden on medical infrastructure, and lessens exposure to infectious diseases for all participants. Advances in technology and the advent of more sophisticated equipment have increased the extent of patient monitoring via telemedicine and have resulted in increased physician and patient satisfaction.

Enacting a permanent telehealth policy will help provide more predictability and help foster greater investment into this critical tool. Currently, many essential Medicare telehealth flexibilities are set to expire on December 31, 2024.

The ACR supports the Committee's ongoing efforts to enact a permanent extension of these flexibilities. This is essential to ensure that patients can maintain a stable relationship with their healthcare provider, especially in rural and underserved communities.

Conclusion

Policy reform is needed to support Medicare providers and the patients they serve. Without Congressional intervention, the stability of the current Medicare payment structure will continue to weaken, threatening the ability of physicians to provide care to Medicare beneficiaries. By tying the Medicare conversion factor to inflation and raising the budget neutrality threshold, this Congress will infuse the fee schedule with needed financial stability and predictability to provide immediate relief to providers. Going further, Congress may encourage meaningful APM participation by streamlining program requirements, counting participation in Qualified Clinical Data Registries towards MACRA participation and minimizing barriers to entry.

The ACR looks forward to partnering with the Finance Committee as legislative solutions are considered. Please contact Lennie McDaniel, JD, Director of Congressional Affairs, at LMcDaniel@rheumatology.org should you have any questions or need additional information from the ACR or its membership.