AMERICAN OSTEOPATHIC ASSOCIATION

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Official Response

Senate Finance Committee White Paper on Physician Payment Reform

June 14, 2024

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the Committee's interest in improving patient access to care, and making meaningful strides toward addressing the physician payment crisis we currently face. Without reforms to the Medicare physician payment methodology, consolidation and physician shortages will worsen, as will patients' ability to access care.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that healthcare stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. We hope our response to the Committee's proposals will advance the development of policies that will provide stability in Medicare payment, support the delivery of high-quality care, and provide lasting solutions to problems that have long plagued both patients and physicians across America.

Conversion Factor:

In order to protect and maintain Medicare beneficiaries' access to care, predictable annual updates to physician payment are needed. As the Committee is aware, physicians are the only healthcare providers under Medicare that do not receive an annual inflationary payment update. In fact, CMS finalized a 3.37% cut to Medicare's physician payments in the 2024 Physician Fee Schedule (MPFS), which was partially mitigated by Congress. This payment cut coincides with ongoing increases in costs to practice medicine – which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. Since 2001, physician payment under Medicare has declined 29% when accounting for inflation.[1] Reversing this trend would not only provide stability to independent physician practices facing unique economic challenges but would also align with the recommendations to Congress, by the Medicare Payment Advisory Commission (MedPAC), to update the base physician payment and enact add-on payments for services delivered to low-income beneficiaries to protect patient access.[2]

Moreover, although an inflationary update for the MPFS would increase Medicare spending for care furnished under the PFS, the Committee acknowledges in its white paper that the current cost growth under the MPFS is significantly lower than that of similar services furnished under the Hospital Outpatient Prospective Payment System (OPPS). The Congressional Budget Office (CBO) projects that federal spending on the MPFS will increase by 17% by 2033, while OPPS spending will more than double over that same period.

[1] American Medical Association. "Medicare Updates Compared to Inflation in Practice Costs." March 2024.
[2] MedPAC. "March 2024 Report to the Congress: Medicare Payment Policy." March 15, 2024.

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While the AOA supports annualized inflation-based updates to the MPFS, the AOA also supports policy that would include limits to any increase or decrease to the conversion factor (CF) to a certain percentage, alongside any MEI adjustment. Thus, if required due to budget neutrality requirements, positive or negative swings to the CF rate would have a cap. This change would improve predictability of payment changes for physicians while also allowing for the CF to increase in an economically sustainable manner.

Budget Neutrality:

Medicare's current budget neutrality obligations within the physician fee schedule exacerbate issues of inadequate payment driven by the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS, due to upward payments or new procedures, in one category that increases cost by $20 million or more must be offset by cuts in other areas of the fee schedule. As noted by the Committee in its white paper, this issue is reflected in the implementation of a new and controversial care complexity add-on code (G2211), which led to payment cuts across all services.[3] Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides. The Committee should consider legislation that would increase the budget neutrality threshold to ensure delivery of new procedures or upward adjustments for certain specialties do not harm patient access to others.

As a result of the impact of even small adjustments to the MPFS or inclusion of new procedures, and the lack of updates to the budget neutrality threshold, the AOA supports policies included in legislation such as the *Provider Reimbursement Stability Act* (H.R.6371). If enacted, the bill would increase the budget neutrality threshold from $20M to $53M and include further threshold increases based on the MEI every 5 years. This would alleviate a significant amount of negative payment adjustments resulting from the budget neutrality threshold while still limiting significant cost increases within the MPFS. The bill would also require CMS to reconcile inaccurate service utilization projections based on actual claims data, and prospectively revise the CF accordingly. The AOA is supportive of policies that would require CMS to compare estimated utilization to actual utilization for each relative value unit (RVU) adjustment that it made in the previous year. CMS would conduct such an analysis by September 1 of the subsequent year after adjustments were made. If there was either an overestimation or underestimation of utilization, CMS would then be required to adjust its estimations for the following year in order to reconcile the difference. This process would ensure more accurate cost projections and would help ensure CMS' release of claims data remains up to date and usable for policy reforms.

Alternative Payment Models:

Given the whole person, patient centered approach of the osteopathic profession, the AOA is well positioned to engage as the Committee considers new, alternative payment policies that "[orient] toward patient-focused, longitudinal care, with an emphasis on promoting team-based coordination among primary and specialty care clinicians…"[4] The AOA has long endorsed payment models that are designed around the above approach to care.

[3] Ibid.
[4] Senate Finance Committee. "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." Page 17. May 17, 2024

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However, transitions to value-based payments must account for the unique needs of different specialties, practices' current capacities, and the ways physicians deliver care – particularly in rural areas. It also must not create additional barriers to entry for practices, result in reduced or inequitable payment, or increase administrative burden.

CMS has recently launched several demonstrations that the AOA believes are promising for driving greater participation in Advanced Alternative Payment Models (A-APM), including among smaller practices. For example, the AOA is supportive of CMS' efforts to test various prospective payment approaches for primary care through the Making Care Primary (MCP) and ACO Primary Care Flex (ACO PC Flex) Models. Overall, the AOA believes that enhanced, stable per-beneficiary payments can support the delivery of comprehensive care. At the same time, many primary care practices have decided to join accountable care organizations (ACOs) and participate in the Medicare Shared Savings Program (MSSP). Under these programs, physicians will continue to bill under fee for service but are accountable for overall patient costs by taking on risk for losses and savings.

The success of the MSSP is reflected in the savings it has generated for Medicare and the fact that nearly 50% of FFS beneficiaries are aligned to an ACO.[5] However, there are a broad range of factors that can influence whether a practice is successful under these models, and the AOA believes practices must have the flexibility to choose whether or not to participate in the models that may or may not align with their care delivery methodology and the needs of their patient population.

While the AOA is supportive of bonus and incentive payments for physicians who enter into A-APMs or other value-based care delivery models, the specific methodology for those incentives cannot utilize a one size fits all approach. Most of the current APMs calculate payment using an underfunded FFS Medicare infrastructure that can result in underpayment and exacerbate challenges in persuading physicians to participate in APMs. A-APMs will struggle to attract participants and deliver improvements to quality of care if they hold physicians accountable for a broad and complex range of services while continuing to underpay physicians for patient utilization of those complex, high-value services. Moreover, physicians need a diverse range of options to ensure that models align with the needs of both their practice and patients. With that in mind, the AOA supports reducing the thresholds to become a qualifying participant (QP) or partial QP for bonus and quality reporting purposes. Lowering the threshold would better support small and independent physician practices, particularly in rural areas, who may struggle to meet patient and revenue thresholds for A-APMs but are still interested in participating.

Small practices face four significant barriers to entry into A-APMS. First, they tend to lack the staff and technical infrastructure required to effectively participate in most quality-based models. Second, thin margins preclude them from being able to take on additional risk or make the significant financial investments needed to effectively participate in A-APMs. Third, small practices within AOA's membership report significant concerns regarding onerous quality reporting that takes time away from physicians' ability to see patients. Finally, physicians report a fear of failure within the A-APM due to inability to track performance in real time and make needed course corrections.

[5] Centers for Medicare & Medicaid Services. "Participation Continues to Grow in CMS' Accountable Care Organization Initiatives in 2024". January 29, 2024. Available here.

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Similarly, due to reduced payment, increased costs, and lower volume, many small practices and provider groups struggle to afford the necessary investments in both technology and clinical staff to be able to successfully participate in A-APMs. Incorporating advance payments for infrastructure into A-APM models would help support care transformation and support participation by practices of all sizes and geographic locations. Additionally, the process of making infrastructure improvements is time-intensive, and many practices may not be ready to fully assume risk during their first year of participation in an A-APM as they continue to make practice improvements.

The AOA supports models implementing glide paths in which participants can take on increasing amounts of risk as they transition from FFS into the A-APM in exchange for higher performance-based payments and bonus amounts. Similarly, the Committee should place a significant emphasis on burden reduction for qualifying participants. Any future models or expansions of existing models should ensure that physicians must only report on a more limited set of "high impact" quality measures. A-APMs are designed to hold participants accountable for both care quality and costs over the long-term. Ensuring that QPs are granted relief from burdensome quality reporting requirements in exchange for adopting comprehensive services that support long-term health and reduce Medicare expenditures is the most effective way to support the transition to longitudinal quality care.

As the Committee considers the best way to measure quality in primary care while reducing burdens for physicians, the AOA supports alignment with CMS' universal foundation measures for primary care. When evaluating quality for other specialties or specialist services, other measures may be more appropriate. Regardless of specialty, A-APM participants must be able to track their performance in real-time to be able to adjust as needed. Time lags between care delivery, feedback, and payment adjustment can be a challenge for physicians seeking to improve care delivery.

Finally, A-APMs must also be designed to account for the higher care delivery costs associated with providing care for complex patients and patients with various social risk factors. When caring for these patients, a key element of comprehensive care is not only managing their complex conditions but also working to address social risks that can result in poorer outcomes. Payments must be adjusted to reflect such complexities in physicians' patient population.

In sum, a primary care A-APM must be able to assure physicians that their participation will result in a net enhancement to payment if they perform well. Any incentive payments should be made in addition to FFS payment the physician would otherwise receive for the services rendered. A-APMs are currently built upon an underfunded foundation of FFS where payment is not updated to account for rising practice costs. Any new primary care payment policy based upon A-APMs that does not account for the increasing cost of delivering care, with predictable annual payment updates, will set up the participating practices for failure and result in the same challenges we currently face.

Merit-based Incentive Payment System (MIPS):

As the Committee considers policies that could encourage improvements to the quality of care under FFS, the Committee should focus on reforms to MIPS. We appreciate the Committee's acknowledgement that MIPS may be "ineffective at measuring quality improvement among physicians" given the limited and often inaccurate scope of quality measures within MIPS, and that physicians who care for complex patients are more likely to be penalized than

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rewarded for MIPS participation.[6] The AOA agrees with the Committee that comprehensive reform of MIPS, including scaling back or repealing the program, is necessary to promote high quality care, alleviate physician burden, and support equitable payment to physicians.[7] First, the current "tournament style" model, wherein penalties for poor performance fund the bonuses for strong performance with no additional funding source, is highly inequitable as scores have not shown to reflect the actual quality of care provided. For example, physicians in small and rural practices consistently receive below-average MIPS scores, demonstrating that practice size and resources are better indicators of MIPS performance than patient outcomes. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering demonstrably better quality of care.[8] Overall, AOA recommends that:

- MIPS be reformed to enhance measurement accuracy and clinical relevance, particularly within the cost performance category, to better target variability that is within the physician's ability to influence (e.g. flaws in methodology for the total per capita cost measure);
- CMS be required to provide physicians with timely, actionable feedback throughout the performance year so that physicians can respond and adjust in real-time;
- Allow for multi-category credit for measures that inherently satisfy more than one performance category;
- Allow greater flexibility in cost measure development by eliminating the requirement that CMS must account for at least one-half of all Parts A and B expenditures with its cost measures;
- Ensure greater flexibility for specialists such that performance under the quality category does not require them to report generic measures irrelevant to their practice;
- Incentivize physicians to adopt and report on new measures to better promote development and refinement of measures.

Focusing on high-impact measures, ensuring more equitable scoring, and ensuring physicians have actionable real-time data on their performance will promote improved care quality. Additionally, ensuring physicians can receive cross-category credit under MIPS could help reduce burdens while still promoting quality. While these incremental changes would make marginal improvements to MIPS, they would not address fundamental issues with the basic nature of MIPS payments. For example, the "tournament style" bonus structure subject participants to significant risks given already declining Medicare payments with very minimal upside. As the Committee notes, the largest MIPS bonuses to date have amounted to only 2.34% while the maximum is penalty -9%.[9]

Chronic Care Management (CCM):

Nearly 95 percent of adults aged 60 and older have at least one chronic illness or condition, and nearly 80 percent of the same cohort have two or more chronic conditions.[10] Over the next decade, the projected number of patients with

[6] Senate Finance Committee. "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." Page 18. May 17, 2024.
[7] Ibid.
[8] Johnston K, Wiemken T, Hockenberry J, et al. Association of Clinician Health System Affiliation with Outpatient Performance Ratings in the Medicare Merit-based Incentive Payment System. *JAMA Netw Open. 2020;324(10):984-992*
[9] Jeffrey Davis. "The MIPS Effect: A Surprise Twist in Estimating Medicare Payments for Clinicians Next Year." McDermott+ Consulting. August 24, 2023.
[10] National Council on Aging. Chronic Inequities: Measuring Disease Cost Burden Among Older Adults in the U.S. A Health and

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at least one chronic condition is expected to double and encompass more than 142 million Americans by 2050, placing increasing strain on the U.S. healthcare system and workforce.[11] In comparing the United States with nine other high-income nations, the United States has significantly lower rates of patients reporting a longstanding relationship with a primary care physician.[12] At the same time, evidence shows that longitudinal relationships, which are integral to both the philosophy of osteopathic medicine and delivering high-quality care, lead to better management of chronic conditions and improved patient outcomes.[13] Investment in physician payment, especially in primary care, is needed to build chronic disease care capacity across the country.

While the AOA strongly supports payment policies that ensure patients can receive chronic disease management and physicians are paid adequately for their services, reforms cannot come at the expense of other specialties or physicians' ability to make choices about their practice. As noted above, the AOA is supportive of policies that would develop value-based contracting options so that physician practices can select the best payment model that supports their delivery of care. The AOA is also supportive of A-APMs that effectively distinguish between primary care and specialty services. As a result, a hybrid per-beneficiary, per-month (PBPM) model for primary care under FFS that requires all physicians to participate, or privileges one care modality over another in terms of payment, is not something the AOA would support.

The AOA remains interested in continuing to work with the Committee to create an opt-in PBPM model for primary care that is similar to an A-APM, which ensures physicians are paid adequately and includes annual updates. Similar to what we have noted regarding APMs more broadly, we believe that any new primary care PBPM approach must account for underpayment to primary care under our current FFS infrastructure and conform to the following.

1. Any bundled payment methodology should be developed through a physician-led process to ensure that bundles account for the right services, appropriate payment, and minimized reporting burden.
2. Total payment per beneficiary should be outside the PFS budget neutrality parameters and must be sufficient to broadly account for the broad range of services primary care physicians provide when delivering comprehensive, coordinated care, and should not result in a net reduction in payment for services (excluding payment adjustments associated with risk-bearing), including when accounting for beneficiary cost-sharing.
3. Financial incentives should be tailored around improving care and delivering care efficiently.
4. Payment should be predictable and enable small and independent practices to participate successfully and reasonably manage revenue.
5. Payments should be risk adjusted in a manner that appropriately reflects physicians' patient populations, accounting for social risk factors, diagnoses and patient complexity, income/dual eligibility status, and other factors.

Retirement Study Analysis. Page 5, Figure 2. April 2022. Accessed online at: https://ncoa.org/article/the-inequities-in-the-cost-of-chronic-disease-why-it-matters-for-older-adults.

[11] Ansah JP, Chiu CT. Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. Front Public Health. 2023 Jan 13;10:1082183. doi: 10.3389/fpubh.2022.1082183. PMID: 36711415; PMCID: PMC9881650.

[12] Gumas ED et al. "Finger on the Pulse: The State of Primary Care in the U.S. and Nine Other Countries," March 28, 2024. The Commonwealth Fund. Accessed online at: https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/finger-on-pulse-primary-care-us-nine-countries.

[13] Jennifer Arnold, "Fostering Long-Term Doctor-Patient Relationships to Improve Outcomes," Duke Health, January 17, 2017.

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6. When physicians are accountable for total costs, they should be granted relief from administrative burdens and be exempted from MIPS, only being subject to a limited set of high-impact quality measures that are most meaningful to physicians and patients.
7. Physicians must receive regular updates on their cost performance.
8. Outlier high-cost drugs and services should be excluded and paid separately at full FFS rates, where applicable.
9. Payments should be updated annually to account for increases in the cost of practicing medicine.

Considering that 80% of Medicare-aged patients have two or more chronic conditions, appropriate risk adjustment is essential to ensuring payment sustainability for many practices within a hybrid PBPM model design to ensure physicians are rewarded for taking on the care of sicker populations. Models from the Center for Medicare and Medicaid Innovation (CMMI), such as the Kidney Care Choices model, already use a risk adjustment design specifically for model participants. This design ensures that payments are fairer and more reflective of the higher-risk patients being served within the model, and by different participants. If the Committee were to propose a policy that creates a voluntary hybrid PBPM design for primary care, physicians should be able to receive payment adjustments for patients who require more resources and more intensive, longitudinal care.

If implemented, a hybrid PBPM model must be built with reducing physician burden in mind. The model can account for quality of care by utilizing similar methodologies to A-APMs. Many A-APMs are well-suited for physicians helping patients manage chronic care conditions as they include added incentives for physicians who take on additional risk as they deliver high quality, coordinated, and accountable care. Building a model with hybrid payments, specifically focused on chronic care management, could include similar levers. Additionally, the Committee could consider benefit design flexibility that improves access to patients seeking chronic disease management services, including policies that would allow for pre-deductible and/or $0 copay coverage of chronic care services. If such a policy were to be implemented, it would need to be designed such that physicians can accurately and effectively bill Medicare for copay costs associated with chronic disease management, which would likely increase per-beneficiary spending under the MPFS.

Within FFS Medicare, the Committee should focus on policies that promote long-term physician-patient relationships. As noted above, services that support longitudinal relationships between patients and physicians yield improved outcomes. This includes the ability for patients to access providers via telehealth, use of remote physiologic monitoring, and effective care coordination. However, Medicare payment often does not enable practices to optimize how they deliver and coordinate care for complex patients.

Most notably, Chronic Care Management (CCM) codes were created to help pay for comprehensive services to patients with complex needs. An analysis by Mathematica on patients who received these services found that CCM was effective at reducing downstream costs, with savings increasing over time. However, only 4% of eligible Medicare beneficiaries receive CCM because 1) it entails substantial documentation burden that requires staff time to comply with, 2) patients must opt in to these services, and 3) patients face substantial cost sharing by opting in.[14]

[14] NORC University of Chicago. "Analysis of 2019 Medicare FFS Claims for CCM and TCM Services." March 1, 2022.

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Compounding the issues of stagnant physician payment, primary care payment continues to be undervalued relative to specialist services, limiting practices' ability to make investments in transforming how they deliver care.

The AOA strongly supports the Committee's goal of providing policy solutions to ensure adequate care for patients with chronic diseases and looks forward to engaging further to create a sustainable approach.

Ensuring the Integrity of the PFS:

The AOA supports policies that would improve program integrity, reliability, and accuracy in CMS' rate-setting processes. In recent years, the share of overall physician payment that practice expense accounts for has steadily increased as the inputs for this component (including rent, medical supplies, equipment, staff labor, EHRs, etc.) have increased. However, the AOA is concerned that a lack of a standardized, routine approach to collecting data on practice expense for updating MEI weights results in inaccurate updates that may overvalue practice expense relative to physician work, an approach that disadvantages office-based physicians that predominantly provide cognitive services, relying less on costly technology and supplies. Because implementation of MEI weights is budget neutral, increases to the relative share of payment is accounted for by practice expense results in reductions to payment for physician work and liability.

Currently, CMS is relying on a nearly 20-year-old data for updating practice expense. While we appreciate that CMS has delayed updates until the AMA completes a comprehensive practice expense survey, AOA believes a more systematic approach that regularly updates cost inputs should be adopted. Additionally, any changes to practice expense should support equity across sites of care, ensuring that facilities are not inappropriately overpaid for rendering the same service as a physician office.

The AOA supports policy that would require CMS to update the prices and rates for each of the direct cost inputs every five years, and in consultation with medical societies.

Similarly, the AOA strongly supports the RVS Update Committee (RUC) as the entity best suited to provide recommendations to CMS on the relative values of physician services, as well as their cost inputs, and does not support the establishment of a federal panel or advisory committee that would serve as a substitute or alternative source of recommendations to CMS. As defined under law, physician payment is based on three primary components: physician work, practice expense, and malpractice liability insurance expense. Physician work is determined based on the time, intensity, and complexity of individual services physicians provide. The relativity of each of these components of physician work, as well as the direct cost inputs for services across settings, cannot be appropriately determined without direct physician input.

The AOA is not confident that any alternative to the RUC would account for input from physicians across the 125+ medical specialties, and from these specialties, physicians practicing across a range of settings, from small and rural practices to large multi-specialty groups to hospital-based physicians.

As a result, the AOA firmly believes that the RUC is the entity best situated to make recommendations regarding resource inputs for services. The RUC is comprised of volunteer physicians across specialties that work to evaluate

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the value of services based on a system of relativity, utilizing survey data generated by physicians in active practice who render a given service. The RUC process generates granular data to describe the physician time, work relativity, clinical staff time, medical supplies and medical equipment used in providing services to patients.

The AOA also supports the reestablishment of CMS' RUC Refinement Panel process which was discontinued in 2016. This process served as a relative value appeal process to provide independent review of values and ensure that values adopted by CMS reflected the practice of medicine. For the 25 years it was in place, CMS convened the Refinement Panel comprised of representatives across Medicare carriers to carefully review public comments, hear testimony from practicing physicians, and recommend refinements to relative values. The AOA believes that continuing to rely on the RUC's input, while also reestablishing this panel for appeals within CMS, will ensure integrity of CMS' rate setting process.

Input from practicing physicians and clinical physician leadership via the RUC process is essential to the process of valuing services because these individuals are in the field and intimately understand the inputs for the services they provide to patients. There is no other entity that collects data with the level of detail and broad specialty input as compared to the RUC, and thus equally capable of assessing the value of services.

Conclusion

Again, thank you for the opportunity to submit a formal response to the Committee's white paper on this incredibly important topic. The Committees' work on these important issues will support the stability of both the independent physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and improve practice sustainability for physicians across the country. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Federal Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.