



American College of Osteopathic Internists • Stay True to Why You Pursued Medicine

June 18, 2024

The Honorable Ron Wyden  
Chairman  
Senate Committee on Finance  
221 Dirksen Senate Office Building  
Washington, DC 20510

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

Dear Chairman Wyden and Ranking Member Crapo:

The American College of Osteopathic Internists (ACOI) appreciates the opportunity to submit comments in response to the bipartisan Senate Finance Committee white paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." The ACOI represents the nation's osteopathic internists, medical subspecialists, fellows, residents, and students.

As a society that includes members who care for patients with chronic conditions, ACOI agrees with statements provided during the April 11 Finance Committee hearing that traditional Medicare is falling behind in the payment and delivery of care for seniors with chronic conditions. However, the scope of the challenges facing Medicare, its enrollees and the physicians who care for them are pervasive.

The Medicare physician payment system is on an unstable path that threatens beneficiary access to care. In their May 2024 report, Medicare's Trustees noted that current-law negative payment updates for physician services will be below the rate of inflation in all future years and, consequently, patient access to Medicare-participating physicians is expected to become a "significant" issue. A primary concern among ACOI members is the continuation of the statutorily set update of zero through 2025, and, starting in 2026, updates of just 0.75 for qualified physicians in advanced alternative payment models (A-APMs), and 0.25 for all other physicians. These updates are inadequate, and, as noted by Medicare's Trustees in 2023, "do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases." Inadequate payment updates have been felt most acutely by physician practices as they contend with a tight health care labor market that is driving up wages for non-physician practitioners who are increasingly being relied upon to fill gaps to meet patient care demands, as well as medical technologists, and administrative staff.

In an uncertain environment, physicians seek shelter by becoming employees of hospitals or corporate entities. According to the data from Avalere gathered in a study sponsored by the Physicians Advocacy Institute, six out of 10 (58.5%) physician practices are now owned by hospitals, health systems and other corporate entities. This dramatic shift from independent physician practice to employment is punctuated by the staggering statistic that more than three quarters (77.6%) of U.S. physicians now work for hospitals, health systems, or corporate entities.



With Medicare reimbursement that has not kept pace with inflation, payment cuts on the horizon and regulatory and administrative burdens, the trends in practice consolidation and acquisition are not shocking and come at a cost to the Medicare system and to patients.

A fundamental restructuring of the Medicare physician payment system is needed, but we acknowledge it may take time. We appreciate that this white paper explores potential policy solutions and that the Committee is interested in working with stakeholders to inform its legislative process. We ask that, at a minimum, Congress ensure that physicians do not sustain another cut to their Medicare payments next year.

#### *Addressing Payment Update Adequacy and Sustainability*

Even after congressional intervention earlier this year, physicians are still experiencing a Medicare payment cut of nearly 2 percent. Hospitals, skilled nursing facilities, and ambulatory surgery centers all received an automatic annual update tied to inflation. **ACOI supports and asks Congress to pass the “Strengthening Medicare for Patients and Providers Act,” (H.R. 2474) which provides a permanent annual update equal to the increase in the Medicare Economic Index (MEI).**

According to the Medicare Payment Advisory Commission (MedPAC), clinicians’ input costs — as measured by the MEI — grew by 4.6 percent in 2022, with growth projections of 4.1 percent for 2023, 3.1 percent in 2024, and 2.6 percent in 2025. Despite the significant growth of clinicians’ input costs, MedPAC has recommended that Congress update physician payments for 2025 at half of MEI, which would be 1.3 percent based on current projections.

MedPAC justifies its recommendation of providing just half of MEI on the basis that clinicians’ practice expenses account for about half of the MEI. While ACOI appreciates the recognition by MedPAC commissioners that physicians deserve a positive payment update and that it be permanent and built into subsequent years’ payment rates, half of MEI fails to address years of Medicare physician underpayment that is a driver of physician practice consolidation and higher health care costs. Payment for physician work — the time, energy, and expertise devoted to treating patients by physicians, nurse practitioners, physician assistants and other qualified health care professionals — contributes to total cost in the provision of a service and is equally impacted by inflation. Therefore, an inflation-based payment update is warranted for all aspects of total physician payment, including physician work, which could be addressed by legislating an update that is tied to full, rather than half, of MEI.

#### *Budget Neutrality Adjustments to the Conversion Factor*

The budget-neutrality adjustment ensures any changes made to the relative values of particular billing codes in the fee schedule do not, in and of themselves, increase or decrease total physician fee schedule (PFS) spending. In 2021, the Centers for Medicare and Medicaid Services (CMS) increased the payment rates for office and outpatient evaluation and management (E&M) visits, upon the recommendation of the American Medical Association/Specialty Society



Relative Value Scale Update Committee (AMA RUC). Increasing the payment rates for these billing codes required an offsetting – 6.8 percent budget-neutrality adjustment to the fee schedule’s conversion factor. We appreciate actions by Congress that prevented a reduction of this magnitude, and which effectively phased in the 6.8 reduction over time. The effect has been substantial increases in payment rates for office and outpatient E&M visits and a reduction to the conversion factor. Consequently, physicians who may have benefited from the increased payment rates for E&M services benefited less than they would have because of budget neutrality requirements.

**ACOI supports the “Provider Reimbursement Stability Act” (H.R. 6371) which would make much-needed reforms to budget neutrality. Specifically, ACOI supports the following changes to budget neutrality requirements:**

- **Increase the budget neutrality threshold from \$20 million to \$53 million and increase the threshold every five years by the cumulative increase in the MEI since the last update to the threshold.** The \$20 million was established in 1992 and has not been updated since. This would allow for greater flexibility in determining pricing adjustments for services without triggering across-the-board cuts.
- **Provide a look-back period to reconcile overestimates and underestimates of pricing adjustments for individual services no later than September 1 of the subsequent year.** This would allow for the Medicare conversion factor to be calculated with more accuracy based on actual utilization data and claims. For example, if CMS proposes something for CY2025 that requires a budget neutrality adjustment based on projections of how much a new code or service was going to be utilized, data would then be collected on the accuracy of those projections, and CMS would propose a correction based on actual CY2025 utilization data for the CY2027 PFS.
- **Require, no less than every five years, updates to prices and rates for direct cost inputs for practice expense relative value units which includes clinical wage rates, prices of medical supplies, and prices of equipment.** CMS did not update supply and equipment prices from 2005-2019 and clinical staff wage rates from 2002-2022. The length between updates made price changes more significant rather than if prices were updated more frequently, which creates larger swings in payment than if more consistently updated.
- **Limit positive or negative increases in the conversion factor to no greater than 2.5 percent each year.** The policy goal is to provide stability for the PFS by removing relatively large and abrupt changes in conversion factor calculations.

#### *Alternative Payment Model Participation*

Qualified physicians in an A-APM will receive an incentive payment amounting to 5 percent of their Medicare payments for 2019–2024 and 3.5 percent for 2025. The law also specifies physician payment rate updates of 0.75 percent annually thereafter for those in A-APMs. These updates are notably lower than the projected physician cost increases, which the Medicare Trustees assume to average 2.05 percent per year in the long range. **To ensure physicians have**



**adequate financial assistance to invest the resources necessary to participate in A-APMs, the five percent bonus should be reinstated and extended. Congress should also maintain for two years the 50 percent revenue-based threshold for becoming a qualified APM participant.** Toward this end, ACOI supports the *Value in Health Care (VALUE) Act (S. 3503 / H.R. 5013)*.

Congress must also ensure there are ample opportunities for physicians to participate in A-APMs. To date, most physicians, physician specialists in particular, still do not have the opportunity to participate in an A-APM that is designed for the kinds of patients they treat. When the Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established under the Medicare and CHIP Reauthorization Act (MACRA), the physician stakeholder community believed the PTAC and its process for advancing physician-focused payment models (PFPMs) offered promise for creating greater APM opportunities for specialty physicians. This has not been the case, and consequently, there has been little opportunity for physician specialists to move into APMs. To date, the Center for Medicare and Medicaid Innovation (CMMI) has not tested or implemented any one of the models recommended by the PTAC.

From 2016 to 2020, PTAC received 35 proposals for PFPMs and voted on the extent to which 28 of these proposals met the Secretary's 10 regulatory criteria. Nearly all of the 35 proposals that were submitted to PTAC addressed the proposed model's impact on quality and costs to some degree. The PTAC noted in a September 2023 communication to Health and Human Services Secretary Becerra that at least 16 of the proposals discussed improving care delivery and specialty integration in advanced primary care models and episode-based or condition-specific models, including care coordination between primary care providers and specialists. PTAC stated it now may be "beneficial for PTAC to reflect on proposed PFPMs that have been submitted to the Committee to provide further advisement on pertinent issues regarding effective payment model innovation in APMs and PFPMs."

**As the Committee considers statutory changes to facilitate A-APM participation, ACOI recommends a thorough analysis of physician experience in models supported by the CMMI, as well as the extent of ongoing interactions between the PTAC and CMMI and opportunities for revisiting PFPMs that were supported by PTAC but never tested or advanced by CMMI.**

#### *Supporting Chronic Care in the Primary Care Setting*

In a written statement for the April 11 Finance Committee hearing record submitted by the Primary Care Collaborative and the Better Health-NOW campaign, the **groups encouraged the Finance Committee to work with stakeholders toward legislative solutions that make a well-constructed primary care hybrid payment option broadly available.** Such an approach would provide payment to practices up front each month to deliver primary care for patients with an ongoing relationship, coupled with fee-for-service payment for other services. ACOI supports this statement and encourages the Committee to increase options for all primary care practices to benefit from A-APMs that provide advance payments, as well as other financial supports that enable them to successfully participate. At the same time, there must be recognition of the value



of specialty care and support of payment structures that uphold that value, and any increases in payments for primary care should be done outside the rules of budget neutrality.

### *Reducing Physician Reporting Burden Related to MIPS*

Physicians value meaningful quality improvement activities; however, a zero-payment update and another cut to the conversion factor make it increasingly difficult for practices, especially solo and small practices, to dedicate resources to successful participation in MIPS. According to a study published in the *Journal of the American Medical Association* on the costs for physician practices to participate in MIPS, physicians, clinical staff, and administrative staff together spend 201.7 hours annually on MIPS-related activities at a per-physician, per-year cost of \$12,811. Furthermore, according to a survey conducted by the Medical Group Management Association, 94 percent of physician practice respondents said positive payment adjustments do not cover the costs of time and resources spent preparing for and reporting under MIPS.

The burden of participation falls disproportionately on small practices. In fact, in the CY 2024 Medicare PFS proposed rule, CMS estimated under its 2024 MIPS policies, eligible clinicians in groups smaller than 100 clinicians would be *more than 60 percent likely* to face a MIPS penalty in 2026. The threat of additional payment reductions (that get redistributed to larger group practices — which may be owned by hospitals and large health systems) for unsuccessful participation in a program that is administratively burdensome and costly for small practices is fundamentally unfair.

To reduce the burden on MIPS participation, **ACOI recommends a number of legislative modifications that align with a proposal developed under the leadership of the AMA and with the involvement of several medical societies.** This proposal, referred to as a new “Data-Driven Performance Payment System (DPPS),” would:

- Address steep penalties that are distributed unevenly by freezing the MIPS performance threshold for three years.
- Eliminate the unsustainable MIPS win-lose style payment adjustments and instead link physicians’ MIPS performance to their annual payment update (e.g., the percentage increase in MEI), creating more alignment across Medicare payment programs.
- Reinvest penalties in bonuses for high performers, as well as investments in quality improvement and APM readiness aimed at assisting under-resourced practices with their value-based care transformation, with an emphasis on small practices, rural practices, and practices that care for underserved, minoritized, or marginalized patients.
- Hold CMS accountable for fulfilling its statutory obligations by exempting from DPPS penalties any physicians who do not receive at least three quarterly data reports during the relevant performance period.
- Make MIPS more clinically relevant and less administratively burdensome by:



- Remove siloes between the four performance categories to maintain accountability while reducing administrative burden.
- Bring the program into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.
- Recognize the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via “yes/no” attestation of using CEHRT or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means.
- 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.
- Align cost and quality goals. Currently, quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies.
- Improve quality measurement accuracy by incentivizing physicians to test new or significantly revised measures, including QCDR measures, by awarding pay-for-reporting credit for three years.

### *Supporting Chronic Care Benefits in FFS*

Removing beneficiary cost sharing for chronic care management services is one way to improve the uptake of these services. Importantly, more must be done to prevent the onset of chronic diseases and to diagnose chronic conditions earlier, including before individuals reach Medicare-eligibility age.

The “Affordable Care Act” requires coverage of preventive screenings and services without beneficiary cost sharing that receive a grade of “A” or “B” from the U.S. Preventive Services Task Force (USPSTF). The nature of how and the process by which the Task Force makes its recommendations may, in fact, be limiting access to certain preventive services in smaller, at-risk populations. For example, it is well-established that patients with diabetes are at increased risk of a limb amputation from peripheral artery disease (PAD). Yet, these at risk-patients, who may have PAD but are asymptomatic may never be tested until they become symptomatic. During the Committee’s April 11 hearing, Steven Furr, MD spoke about a patient who needed revascularization of a limb and, without it, would need a leg amputation at a significant cost to the health care system. These costly services and adverse medical outcomes can be prevented through early detection using low-cost screening measures in high-risk populations. More needs to be done to reduce patient barriers, including out-of-pocket costs, to effective screening and preventive services that do not have an “A” or “B” rating from the USPSTF.



In that regard, it is also important that Congress be able to consider the long-term economic benefits of legislation that promotes wellness and disease prevention and reduces the incidence of chronic conditions; yet it is constrained from doing so by the 10-year Congressional Budget Office (CBO) scoring window. The “Preventive Health Savings Act,” ([S. 114/H.R. 766](#)) provides the Chair and Ranking Member of either budget or health-related committees in the House and Senate with the ability to request an analysis of the two 10-year periods beyond the existing initial 10-year window. Current CBO scoring methodologies have been a barrier to enactment of legislation aimed at improving access to preventive services. ACOI urges passage of S. 114 / H.R. 766 before the end of the 118th Congress with the hope it will facilitate passage of legislation in the future that will help reduce the burden of chronic conditions on the American public and our health care system.

*Conclusion*

ACOI appreciates your leadership on Medicare physician payment policy and improving the health of our Medicare beneficiary population, including preserving telehealth services under Medicare fee for service. Thank you for consideration of ACOI’s feedback. Requests for additional information or questions should be directed to Tim McNichol, ACOI Deputy Executive Director, at [tmcnichol@acoi.org](mailto:tmcnichol@acoi.org) or (301) 231-8877, or Camille Bonta, ACOI consultant, at [cbonta@summithealthconsulting.com](mailto:cbonta@summithealthconsulting.com) or (202) 320-3658.

Sincerely,

A handwritten signature in black ink. The signature is stylized and appears to read 'R. HASTY'. To the right of the signature, there is a handwritten note that says 'DO FACOI'.

Robert T. Hasty, DO, FACOI  
President, American College of Osteopathic Internists