STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Re: “What’s the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors”

October 19, 2023

Division of Legislative Counsel 202-789-7426

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Health

Re: "What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors"

October 19, 2023

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health as part of the hearing entitled "What's the Prognosis? Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors." As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA works tirelessly to ensure health care access and coverage for Americans across the nation, especially for the country's most vulnerable patient populations. We appreciate the Committee's interest in examining the best pathway forward toward a Medicare physician payment system (MPS) that rewards clinicians who deliver high quality care and preserves access to Medicare beneficiaries moving into the future.

The cost of practicing medicine is rising at the fastest rate in decades, yet physicians face a confluence of Medicare payment cuts next year due to statutory budget neutrality requirements, expiration of temporary updates, and unfair penalties under the Merit-based Incentive Payment System (MIPS). Other time consuming and expensive administrative burdens are keeping physicians away from patient care and adding unnecessary costs to the health care system. The current physician payment system is on an unsustainable path that is jeopardizing patient access to physicians. We are burning physicians out at a time when an estimated 16,000 seniors a day are entering the Medicare system and there is a nationwide physician workforce shortage. Without systemic reforms, including annual inflation-based updates, the current Medicare physician payment system will continue to drive private practices out of business.

TO PRESERVE ACCESS TO CARE, PHYSICIANS NEED FISCAL STABILITY

Under current law and the proposed 2024 Medicare Physician Payment Schedule (MPS), the 2024 Medicare physician payment conversion factor would be reduced by 3.36 percent from 2023. This cut coincides with historic growth in the cost to practice medicine as the Centers for Medicare & Medicaid Services (CMS) projects the increase in the Medicare Economic Index, which is the federal government's measure of annual changes in physicians' operating costs, will be 4.5 percent in 2024.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. We already know how that story ends, and it is not a happy ending. According to the Medicare Trustees, if physician payment does not change, access to Medicare-participating physicians will become a significant

issue in the long term. Some Medicare patients are already experiencing inequitable delays in care, and we know that when care is delayed, health outcomes worsen. These problems particularly impact minoritized and marginalized patients[1] and those who live in rural areas.[2] Will patients with Medicare have to wait six months to see a neurologist when they can no longer remember what day of the week it is? Will they have to wait eight months for an appointment with an oncologist about a persistent lump? Will they forego an endoscopy or mammography because the nearest gastroenterologist or radiologist who accepts Medicare is more than an hour away? We are urging both Congress and CMS to intervene before these problems get any worse.

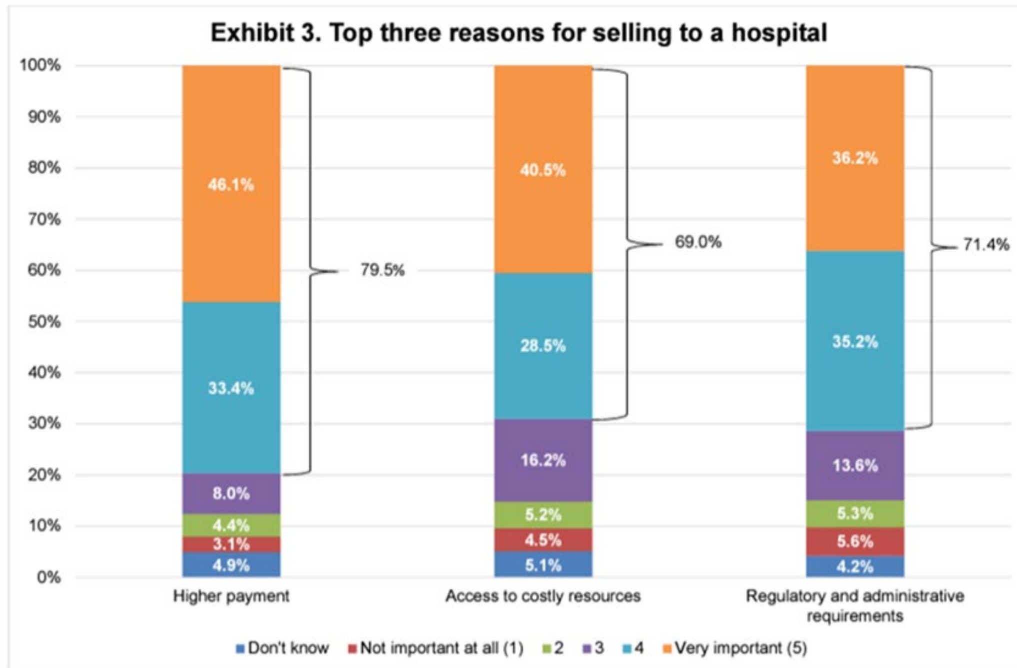
We appreciate that in the Consolidated Appropriations Act of 2023, Congress partially mitigated a 4.5 percent cut to Medicare physician payment rates, but physicians still endured a two percent pay cut this year and for 2024, physicians are facing another 3.36 percent cut, once again confronting the grim task of reconciling how to keep their lights on while getting paid less, while their expenses continue to rise. In fact, between 2001 and 2023, the cost of running a medical practice increased 47 percent, or 1.8 percent per year. In striking contrast, physician payment rates have increased just nine percent over the last 22 years, or 0.4 percent per year, according to data from the Medicare Trustees. Adjusted for inflation, Medicare physician payment rates declined 26 percent from 2001 to 2023, or by 1.3 percent per year.

Hospitals, skilled nursing facilities, and nearly every other Medicare provider receive an automatic annual update tied to inflation. Physicians compete in the same marketplaces as these providers for clinical and administrative staff, equipment, and supplies. Yet physicians are at a significant disadvantage due to payment cuts and because their payments have failed to keep up with inflation. Furthermore, hospitals have multiple sources of relief during times of high inflation, including the 340B program and Disproportionate Share Hospital (SDH) payments to account for uncompensated care. It is no wonder that these trends are driving consolidation, which is highly likely to increase future Medicare costs as these other providers receive increasingly higher payments than the diminishing number of independent medical practices. The Biden Administration has recognized that health care consolidation is leaving many areas, particularly rural communities, with inadequate or more expensive health care options. As discussed in detail below, consolidation in the hospital market is also shown to increase health care costs and lead to worse outcomes.

A new AMA analysis shows that by far, the most cited reason that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment. Next were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. Included below is an excerpted figure with more detail. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to have the ability to practice independently.

[1] See e.g., Johnston KJ, Hammond G, Meyers DJ, Joynt Maddox KE. Association of Race and Ethnicity and Medicare Program Type With Ambulatory Care Access and Quality Measures. *JAMA.* 2021;326(7):628–636. doi:10.1001/jama.2021.10413.

[2] https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-Access-to-Specialty-Care_12.4.pdf.



Source: Author's analysis of AMA 2022 Physician Practice Benchmark Survey.
Note: These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were practice members at the time of that acquisition (N=282). The bracketed percentage is the sum of important (4) and very important (5).

Earlier this year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase 2024 Medicare physician payments above current law by linking the payment update to the MEI, something the AMA and organized medicine have long supported. MedPAC raised concerns about the growing gap between what it costs to run a medical practice and what Medicare pays.

The AMA is strongly urging the Biden Administration to mitigate the reduction to the 2024 Medicare conversion factor; however, the reduction stems largely from the expiration of a temporary update and statutory budget neutrality requirements, which means physician payment will again be cut in 2024 unless Congress intervenes. The annual "stop the Medicare payment cut" exercises are due, in no small part, to the fact that physician services do not receive the annual inflationary update that virtually all other Medicare providers can rely on to better weather periods of fiscal uncertainty. The COVID-19 pandemic further illustrated the challenges physicians endure due to the current broken Medicare payment system. While the temporary and partial patches that Congress has provided through 2024 were necessary under the current payment system, they are a distraction, exacerbate budgeting challenges for practices, and divert resources that both medicine and Congress could be spending on other meaningful health care policies and innovations. Therefore, organized medicine is united in support of a long-term payment solution that centers on annual inflationary updates.

We strongly support H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care. At a minimum, Congress should end the freeze on Medicare physician payment updates under MACRA and provide a one-year update that reflects the increase in the MEI. This would serve as a down payment on long-term reforms.

PROVIDER REIMBURSEMENT STABILITY ACT OF 2023

Physician payments are further eroded by frequent and large payment redistributions caused by budget neutrality adjustments. The AMA strongly supports this draft legislation's provisions that offer practical policy improvements to provide some needed stability to the physician payment system by incorporating corrections from data collected during the look back period.

Reconciliation of Budget Neutrality

CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the payment schedule, resulting in permanent removal of billions of dollars from the payment pool. For example, a previous administration based the 2013 budget neutrality offset for Transitional Care Management (TCM) on a significantly greater estimate of initial utilization of the service than what actually occurred. At that time, CMS estimated there would be 5.6 million claims for TCM when actual utilization was just under 300,000 the first year and still less than one million after 3 years of implementation. For 2013, Medicare physician payment schedule spending was reduced by more than $700 million based on the overestimate of TCM utilization. Similarly, CMS overestimated Chronic Care Management (CCM) utilization when adopting that code one year later (4.7 million estimated claims versus 954,000 in the first year).

The overestimates of the utilization for TCM and CCM and the budget neutrality adjustments resulted in permanent reductions in MPS payments disadvantaging physicians. On the horizon, there is the potential for a further overestimate of utilization for an add-on code for "inherently complex" Evaluation and Management (E/M) services. While Congress passed a moratorium on implementation of this code until 2024, CMS believes this service will be billed 38 percent of the time when billable. This assumption is highly speculative given CMS' past overestimates of TCM and CCM utilization.

Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS the flexibility to account for past overestimates of spending when applying budget neutrality. **We strongly urge Congress to require a look-back period (as have been implemented in other payment systems) that would allow CMS to correct for overestimates and return inappropriately reduced funding back to the payment pool.**

Raising the $20 million Budget Neutrality Threshold

The budget neutrality threshold is a level of estimated program spending changes that triggers a budget neutrality adjustment under the MPS. The threshold is designed to ensure that changes to the MPS do not increase Medicare spending. Historically, the threshold was set at $20 million, a figure established in 1989—three years prior to the official rollout of the MPS. This value was initially conceived to determine if RVU modifications would necessitate budget neutrality adjustments. However, this threshold has remained stagnant, with no updates to account for the inevitable changes in economic conditions and inflation over the years.

Increasing the budget neutrality threshold is essential to ensuring that the MPS remains fair and equitable for physicians. The threshold no longer effectively captures the true financial dynamics of healthcare and makes it difficult for Medicare payments to keep up with new medical technologies and services. This can lead to physicians being underpaid for the services they provide, which can have a negative impact on patient care. **We strongly urge Congress to increase the amount to $53 million to best account for past inflation and update the threshold every five years by the cumulative increase in MEI since the last update to the threshold.**

In addition, to help to ensure that the threshold remains at a reasonable level and does not become a barrier to fair Medicare payments, the threshold should be increased every five years based on the cumulative rate of inflation tied to MEI. This would help to ensure that the threshold remains at a reasonable level in the future.

Updating Prices for Direct Expenses for Budget Neutrality Adjustments

The current MPS methodology for calculating practice expense RVUs is based on direct costs incurred by physicians in providing services, such as clinical staff wage rates, prices of medical supplies, and prices of equipment. If the RVUs are not based on timely and accurate data, physicians may not be adequately reimbursed for their costs, which could lead to financial hardship for their practices and reduced access to care for patients.

Congress should require CMS to update the wage rates for clinical labor, the prices of equipment, and the prices of medical supplies simultaneously at least once every five years. A long lag between updates and the fact that they have been done in different years has made the changes more disruptive than necessary for physicians. For example, in 2019, when CMS finally updated supply and equipment prices, there were significant increases in the prices of some commonly used items. This led to financial hardship for some physicians who do not use these supplies and equipment, and so were not expecting the resulting large budget neutrality adjustment to their payments. Requiring CMS to update the prices of medical supplies more frequently would help to ensure that the MPS more accurately reimburses physicians for their costs. Also, conducting labor and supply updates at the same time and more frequently will reduce the amount of redistribution that is necessary to keep the MPS balanced.

RECOMMENDATIONS TO SALVAGE THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive legacy programs: Meaningful Use, Physician Quality Payment System (PQRS), and Value-Based Payment Modifier programs. Throughout the years, the AMA has offered a steady series of constructive recommendations to improve MIPS. As part of our commitment to better enable a well-designed program, we also sought to address the existing gap in quality measures by developing a set of quality measures that would serve as a means of assessing and incentivizing high-quality diabetes preventive care and align with our diabetes prevention work. Unfortunately, the AMA's experience with this process is an excellent example of the many challenges physicians have with MIPS. In addition, for a variety of reasons, CMS has not adopted many of our recommendations to improve the program. Consequently, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic. The AMA had anticipated when MACRA passed that by the time physicians would be subject to significant penalties from MIPS, the challenges with the program would be minimal and there would be many Alternative Payment Models (APMs) for all specialties to participate in. Unfortunately, that is not the case.

In its current form, MIPS is a repackaging of legacy programs, including PQRS. CMS will highlight its efforts to change the program via the new MIPS Value Pathways (MVPs), but MVPs retain the same core rules and requirements of MIPS, despite physicians' recommendations for improvements and early participation in the development of MVPs. By carrying the flawed MIPS policies over into MVPs, CMS is doing the same thing and expecting a different result.

Therefore, further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. The AMA is strongly recommending that Congress make three key changes to MIPS to remedy these problems.

Background

CMS applied automatic MIPS hardship exceptions due to the COVID-19 pandemic in 2019, 2020, and 2021, and accepted applications for COVID-19 hardship exceptions in 2022 and 2023. While we supported these much-needed flexibilities, the program was severely disrupted for five years due to unforeseeable circumstances and, as a result, the gradual implementation of MIPS as originally envisioned by Congress in 2015 under MACRA was not realized. Meanwhile, CMS continues to rachet up the requirements.

As MIPS requirements have continued to increase each year and the penalties (now at nine percent) apply in full, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2024 Medicare Physician Payment Schedule proposed rule, CMS estimates that over half (54 percent) of eligible clinicians (ECs) will receive a MIPS penalty averaging -2.4 percent in 2026. This is in large part due to the proposed increase to the number of points needed to avoid a MIPS penalty in 2024 (the number of points needed now stands at 82 points compared to just 15 points in 2018, the last year that MIPS was fully in effect before the COVID-19 automatic hardship exceptions took effect). Even more alarming, CMS estimates that nearly 65 percent of ECs in solo practices and 60 percent of ECs in small practices would receive a penalty, confirming that this program is penalizing small practices and redistributing those funds to large, well-resourced health systems. To be clear, there is no reason to believe that the disproportionately negative impact on small, rural, and safety net practices is due to differences in the quality or cost of care provided to Medicare beneficiaries. Rather, this discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources.

Additionally, we are hearing alarming reports that physicians are receiving penalties in 2024 for the first time in the program, which will compound the proposed -3.36 percent reduction to the conversion factor. We have serious concerns that a lack of awareness of the expiration of the automatic COVID-19 flexibilities unfairly penalizes physician practices and disproportionately impacts small, independent, and rural practices. Even practices that were historically successful in the program are now expected to receive a penalty in 2024 due to the Cost Category being weighted at 30 percent of MIPS final scores for the first time as the cost measures were not even calculated in the two prior performance years due to COVID-19. Furthermore, there were errors in CMS' coding and measure specifications in the Cost Category that we anticipate will contribute to the number of physicians who will receive penalties. Also, physicians had no way to anticipate, monitor, or improve their 2022 cost performance category score because CMS did not share any data about attributed measures, patients, or observed costs until August 2023—more than eight months after the conclusion of the performance period.

As a possible solution to lessen the 2024 payment cuts, the AMA strongly urged CMS to extend the October 9, 2023, deadline to appeal a MIPS payment penalty and to permit physicians to apply for a COVID-19 hardship exception as part of their Targeted Review request. There is CMS precedent to utilize the Targeted Review process to claim extreme and uncontrollable circumstance (EUC) due to the PHE. Prior to CMS automatically applying the EUC to 2019 performance/2021 payment adjustments, CMS allowed practices to file a 2020 Targeted Review and claim the PHE. Unfortunately, CMS held

strong to their deadline and ignored our plea and potential solution.

In addition to the concerns about the significant increases in MIPS penalties starting in 2024, there is mounting evidence that the program as currently implemented is causing significant administrative burden, raising costs for physician practices, and disadvantaging small, independent, and rural practices, all with no proven improvement on quality outcomes. This discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources. In a 2019-2020 survey, physician practice leaders from a variety of specialties, practice types and locations reported that MIPS caused substantial administrative burden. Key contributing factors cited were constant programmatic changes, data collection and reporting, and interference with patient care. In fact, the program may be exacerbating health inequities by negatively impacting practices that serve medically underserved populations.

In summary:

- **MIPS disadvantages rural and medically underserved populations.** According to the U.S. Government Accountability Office (GAO), practices serving rural and medically underserved patient populations face numerous challenges participating in MIPS, including lack of technology vendor support, high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of changing program requirements. According to another GAO report, similar challenges limit rural practices' abilities to transition to APMs.

- **MIPS does not correlate with improved quality of care.** A 2022 study in *JAMA* found that MIPS may not even correlate with the quality of care delivered and that physicians caring for more medically or socially vulnerable patients were more likely to receive low scores despite providing high-quality care.

- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. The researchers found that the majority of the MIPS activities included reviewing medical records, collecting information from patients, and entering data into the electronic health record.

- **MIPS disadvantages small and independent practices.** Based on our analysis of 2021 MIPS performance data, three times as many clinicians in small practices had MIPS scores resulting in penalties—11.9 percent versus 3.36 percent overall. Further, according to a study in *JAMA*, affiliation with a health system was associated with significantly better 2019 MIPS performance scores.

- **MIPS disadvantages safety net practices and exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.

Furthermore, following an in-depth analysis of the 2021 Quality Payment Program (QPP) Provider Data Catalog, we have found that the files are incomplete and inconsistent and, as a result, it is difficult to drill down in the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case. Ensuring this data is accurate is critically important to ongoing efforts to understand and improve this program, which should be a shared goal of physicians, CMS, and MedPAC.

Specifically, there is one file that contains the MIPS scores for each clinician but does not have any information about the clinician other than their name and national provider identifier (NPI). The National Downloadable File that accompanies this MIPS score file has information about clinicians, such as their specialties and the names of the group or groups with which they practice. However, we have found that there are almost 100,000 NPIs with a MIPS score that are not included in the National Downloadable File. We looked at the 2020 files, and the same problem exists there. In 2020, there were 180,000 NPIs that have a MIPS score that are not in the National Downloadable File. When we looked in the CMS Enrollment File data for that same time period, there were several thousand NPIs with MIPS scores that were not in the Enrollment File. We are strongly urging CMS to explain and correct these inconsistencies between data files, particularly regarding why so many NPIs are missing from the National Downloadable File, and to instruct physicians how to otherwise access this important data.

Finally, there are mounting problems with the MIPS cost measures. First, we are concerned that CMS did not use the most updated Current Procedural Terminology® (CPT®) codes for its Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measure specifications in 2022 and 2023. The AMA reviewed the coding specifications currently posted to the Quality Payment Program website for 2023 and found that the coding specifications for the TPCC and MSPB have not been updated since 2020. The Evaluation and Management (E/M) section of the CPT code set underwent a major update in 2021, resulting in significant changes to the Office & Other Outpatient visit codes. In 2023, other code sets were updated, including the Inpatient & Observation codes, Nursing Facility codes, and Emergency Medicine codes, to name a few. These changes are on top of the usual yearly addition/revision/deletion of codes throughout the set. The CMS MIPS CPT coding specifications for TPCC and MSPB do not align with the CPT codes for the 2022 performance period or the current year (2023).

Additionally, our review of the CPT codes in the Surgical Attribution tab of the MSBP measure identified potential flaws in the coding for the surgical attribution methodology. For example, for a patient admitted to the hospital under the surgical diagnosis-related group (DRG) 040 (Peripheral/Cranial Nerve & Other Nervous System Procedures), it would be expected that a specific neurological procedure as listed in the Medicare Severity-Diagnosis Related Group (MS-DRG) specification was performed. However, in the CPT code mapping, there are many CPT procedure codes listed, such as CPT code 49561 (Repair of trapped incisional or abdominal hernia), that do not correspond to the principal procedures that are associated with the MS-DRG specified. In the case of MS-DRG 040, principal procedures would relate to operating room procedures such as nerve excisions, divisions, extirpations of matter, extractions, releases, and repairs. Selecting inpatient encounters based on the criteria as currently represented would not yield a sensible set of encounters suitable for quality comparisons. **We believe the out-of-date coding in the cost measure specifications will further exacerbate the number of physicians who receive penalties. Consequently, the AMA is recommending that CMS zero out the Cost Performance Category for 2022 and 2023, like it did in 2020 and 2021.**

Furthermore, the AMA is hearing reports that the cost measures are not functioning as intended. We are concerned by reports that group practices are being measured on the TPCC measure despite being excluded from the measure due to Qualified Health Professionals (QHPs) in their group practice billing Medicare directly. Similarly, we heard from hospital based QHPs that they were scored on TPCC despite the inpatient E/M codes being excluded from the measure specifications. We have heard from an internal medicine physician who scored very poorly on the Asthma/COPD cost measure despite performing well on the TPCC measure. It appears that one of the 20 patients attributed to the Asthma/COPD measure had sepsis during the performance period, which had an outsized impact on the physician's score and which was entirely outside the control of the physician.

Ophthalmologists are being scored on the Diabetes cost measure despite not managing their patients'

diabetes or prescribing the medications necessary to control the condition. While CMS agreed to remedy this attribution problem for 2023 and going forward, the agency has not budged on a solution for 2022, leaving ophthalmologists subject to unfair penalties based on performance on a cost measure for a condition they do not manage. We have heard that rheumatology practices are performing poorly on the TPCC measure, likely due to high Part B drug costs. A recent study[3] published in *JCO Oncology Practice* found that oncologists scored poorly on cost measures compared with other specialties in 2018 when the Cost Performance Category made up a relatively small portion of the overall MIPS score. Based on this study and what we are hearing from physicians, the AMA is concerned that neither the TPCC nor the MSPB measures fully account for the variation in costs in the standard-of-care medicine by specialty and that CMS is conducting an apples-to-oranges comparison.

When taken together, these reports raise serious doubts about whether the MIPS cost measures are fairly and accurately assessing variations in costs within the control of MIPS eligible clinicians as intended. We recommend that CMS study and re-evaluate the overall Cost category and the associated measures because it appears that the measures and underlying methodologies are resulting in major unintended consequences that will negatively impact physicians' payment for services provided to Medicare beneficiaries next year and not working as envisioned by Congress. **We strongly urged CMS to reweight this category and correct these problems before they negatively impact payment and patient access to care.**

Lastly, the AMA has tremendous concerns with CMS' process for reviewing and selecting measures for MIPS. The AMA has been a recognized leader in diabetes prevention for the past 10 years and has a long history as a measure developer. Yet, we spent six years and nearly $1 million on developing diabetes screening measures which CMS ultimately twice rejected with little to no explanation. The AMA approached this work holistically as the measures not only satisfy the needs of MIPS but support our larger quality improvement work in which we engage with physician practices and states throughout the country. Furthermore, the measures also align with CMS' focus on chronic conditions, as well as the efforts of the Centers for Disease Control and Prevention who have been a partner with us on all our diabetes work, including the development of these measures.

There are significant problems with a program that requires measure developers to spend extreme amounts of money without any indication (or contradictory indications) that the measures developed will be adopted. The AMA is more resourced than other physician organizations, but it is difficult to justify the investment to continue submitting measures to CMS. Key to achieving MACRA legislation's goals is the availability of an adequate portfolio of appropriate quality measures that is harmonized with improvement to assist physicians with advancing the care of their patients.

The AMA is aware that a number of specialties have had similar problems and, consequently, there are significant flaws in the process that must be addressed. CMS must move to a participatory measure consideration process to better ensure that physicians will find quality measures to use within MIPS and APM that are clinically relevant and meaningful for their practices and settings of care, as well as administratively actionable and useful in providing better care and value for patients. **We urge CMS to evaluate its process for incorporating measures into MIPS and APMs.**

We believe this litany of problems is a wakeup call for all policymakers regarding the serious negative unintended consequences of MIPS, particularly on the heels of the COVID-19 pandemic.

[3] DOI: 10.1200/OP.22.00858 JCO Oncology Practice 19, no. 7 (July 01, 2023) 473-483.

Recommendations

While CMS has tried to improve the program, such as by introducing the MIPS Value Pathways (MVPs) option, these changes are superficial as the agency believes it does not have statutory authority to remedy these problems directly. Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, and underserved practices; help practices transition to value-based care; and increase transparency and oversight in the program. Below we offer three legislative changes that would help to streamline and improve the program, drive quality improvements, and reduce negative impacts on small, rural, and safety net practices, all while reducing unnecessary burden on physician practices.

1. **Congress should mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, independent practices and practices that care for the underserved and allow practices to revitalize quality improvement infrastructures.**

To accomplish this aim, the MACRA statute should be amended to:

- Freeze the MIPS performance threshold for three years to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and transition back to MIPS following a five-year interruption due to COVID-19. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program. Congress should use the 2021 performance threshold of 60 points (out of 100), which CMS established as a transitionary policy to encourage participation on all MIPS measures.

- Eliminate MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to an annual inflation-based payment update (e.g., tied to the Medicare Economic Index (MEI)). Specifically, physicians could be subject to up to a one-quarter reduction in their update based on their MIPS performance, which would be consistent with the Hospital Inpatient Quality Reporting Program.

- Reinvest money from penalties both in bonuses for high performers, as well as investments 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 patients.

2. **Congress should hold CMS accountable for timely and actionable MIPS and claims data.**

Congress recognized the importance of timely data to drive performance improvement, which is why it originally mandated under MACRA that CMS must provide timely (i.e., quarterly) MIPS quality and resource use feedback, as well as claims data to physician practices, similar to the types of data provided to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).[4] Despite this requirement, physicians did not receive their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports are just high-level summary reports.

While CMS also produces an overall program QPP Experience Report, it too is of limited use. For example, the same physician can be counted multiple times if they bill for services through multiple organizations. And a physician can have a low MIPS score for one practice and a high MIPS score for another. On top of that, CMS does not break down performance by physician specialty, site of service, or the type of reporting. The report also fails to show any longitudinal trends about whether quality or cost are getting better or worse, nor does it provide a complete picture of what made a physician or group

---

[4] 1§42 USC 1395w-4(q)(12).

practice successful in MIPS. The AMA's own analysis of several MIPS data files found that they are incomplete and inconsistent. As a result, it is difficult to drill down into the data to better understand how small practices and rural practices, for example, are performing in MIPS and why this might be the case.

No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. This means that physicians do not know in real time or even on a quarterly basis which cost measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs. Furthermore, an in-depth analysis of 2021 MIPS performance data also revealed concerning data inconsistencies too extensive to elaborate on here.

Accordingly, the AMA urges Congress to exempt from penalties any ECs who do not receive at least three quarterly MIPS feedback and claims data reports during the performance period.

3. Congress should make MIPS more clinically relevant while reducing burden.

As discussed above, MIPS is unduly burdensome and has not been shown to improve clinical outcomes or reduce unnecessary costs. Moreover, the program does not prepare physicians to move to APMs.

Therefore, we recommend that Congress amend the statute to solve these problems by:

- Removing siloes between the four MIPS performance categories to allow for multi-category credit, therefore reducing burden.

- Bringing MIPS into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.

- Recognizing the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. The attestation of using CEHRT is consistent with the hospitals' requirements in Promoting Interoperability, as well as current APM requirements.

- Enhancing measurement accuracy and clinical relevance, particularly within the cost performance category, to target variability that is within the physician's ability to influence.

- Aligning cost and quality goals. MIPS rarely evaluates quality and cost on the same patients and for the same conditions, which has been a key factor inhibiting its ability to drive clinical improvement. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. Harmonizing these measures would ensure MIPS is driving high-value care as intended while reducing burden on physician practices.

- Improving quality measurement accuracy by awarding credit for testing new or significantly revised measures, including Qualified Clinical Data Registry measures, for up to three years.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS; provide a bridge to transition to APMs; and promote the intended goals of MACRA

to leverage health information technology, improve quality, and reduce Medicare costs while reducing burden on physician practices more effectively. **Notably, none of these recommendations are expected to score.** We welcome the opportunity to discuss these recommendations in greater detail.

ALTERNATIVE PAYMENT MODELS

Advancing the movement to value-based care in Medicare by implementing APMs for physician services was an important goal of MACRA. Value-based care links payments for services provided to patients to the results that are delivered, such as the quality, equity, and cost of care. 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. There are various types of APMs, including accountable care organizations (ACOs), bundled payment models, primary care medical homes, and others.

The creation of the Center for Medicare & Medicaid Innovation (CMMI) and the Medicare Shared Savings Program (MSSP) aimed to provide a significant boost to Medicare APMs. CMMI was established to test new APMs and the MSSP allowed for the development of Medicare ACOs in which medical practices and hospitals or health systems work together to coordinate all care for a defined patient population. When Congress enacted MACRA in 2015, there were still too few APMs for physician services available, so Congress included an APM pathway and six years of incentive payments. Congress also recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA included the Physician-focused Payment Model Advisory Committee (PTAC) to review and recommend stakeholder-designed APM proposals.

Currently, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. While the goal was to provide opportunities for the majority of physicians to transition into APMs, CMMI models implemented to date often have steep financial risk requirements, lack funding needed to successfully redesign care delivery, and are usually only available in selected regions. In addition, because these APMs must demonstrate savings for Medicare within a short timeframe, they are often terminated instead of being improved and expanded nationwide. In a report on practices in rural or underserved areas, the Government Accountability Office noted that many lack the capital to finance the upfront costs of transitioning to an APM and face challenges acquiring or conducting data analysis necessary for participation. Although the newest primary care medical home model in Medicare, called Making Care Primary, has many promising features, there is also no nationwide primary care medical home model in Medicare, so patients are not benefiting from the improvements in preventive care, health care quality, and management of chronic conditions that medical homes can provide.

A great source of frustration to the physician community is that, despite the many stakeholder-developed APMs recommended by the PTAC for testing or implementation, no Medicare APMs have been adopted from the PTAC proposals or developed by CMMI to help specialists improve care for patients with chronic diseases like rheumatoid arthritis, heart failure, chronic obstructive pulmonary disease, or inflammatory bowel disease, or patients who would benefit from innovations in surgical care. 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 such as chemotherapy. As a consequence, Medicare patients, especially those outside of the hospital setting, are missing out on the benefits of APMs, including more timely and accurate diagnosis, improved patient-physician shared decision making about treatment plans, preoperative rehabilitation, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

CMMI needs to update its criteria for adopting and expanding Medicare APMs. For example, requiring APMs

to achieve Medicare savings within a very short time span has led multiple medical home and other models to be terminated and limited adoption of specialty models. Meaningful pathways are needed for APM proposals developed by stakeholders, including those recommended by the PTAC, to be implemented in Medicare.

One result of the paucity of APMs for people with Medicare that reflects the experience of frontline practicing physicians has been that the 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 sharp increases in the threshold percentages of APM participation for physicians to qualify for the APM incentive payments, but most APM participants cannot attain the higher thresholds.

Legislation Needed

It is clear that significant changes are needed to realize the robust pathway to APMs that Congress envisioned. Passage of the Value in Health Care (VALUE) Act, H.R. 5013, would be an important step forward in continuing to support the movement to value-based care. Specifically, Congress needs to:

- Reauthorize crucial incentive payments to increase physician participation in Advanced APMs before they expire at the end of 2023.
- Make revenue thresholds that participants need to meet to even qualify for the incentive payments more flexible and realistic, thus preventing abrupt increases schedules to take effect in 2024.

With strong support from the AMA and other key physician stakeholders, a bipartisan group of legislators has introduced this bipartisan legislation to extend the original five percent APM incentive payments included in MACRA and make further improvements to encourage increased APM development and physician participation. The AMA applauded the bill's introduction by Reps. Darin LaHood (R-IL), Suzan DelBene (D-WA), Brad Wenstrup (R-Ohio), Earl Blumenauer (D-OR), Larry Bucshon, MD (R-IN), and Kim Schrier, MD (D-WA). Since this bill falls in the Energy and Commerce Committee's jurisdiction, the AMA urges adoption of H.R. 5013, in full. At the very least, we respectfully request the Energy and Commerce Committee and Congress, as a whole, to pass Section 3 of the Value in Health Care Act. This particular section of the legislation would extend the traditional five percent Advanced APM incentive payments for two years, as well as freeze the revenue thresholds that participants need to meet to even qualify for the bonuses at 50 percent through 2025, thus preventing them from increasing to a near impossible to reach 75 percent in 2024. This section of the legislation also gives the Secretary of Health and Human Services (HHS) the authority to annually increase the revenue threshold but by no more than five percent in a given year, thus allowing for the steady progress towards value-based care to continue at a more reasonable pace.

While we applaud the House Energy and Commerce Committee for releasing a discussion draft bill focused on extending the Advanced APM incentive payments and freezing the revenue thresholds, the AMA has concerns with certain aspects of this legislative approach. First and foremost, the AMA's preference is for the Committee to provide the traditional five percent APM incentive payments for at least up to two years. We also urge the legislation to include provisions freezing the revenue thresholds that need to be met to qualify for the bonuses for 24 months. Most importantly, we urge Energy and Commerce to remove the section of the discussion draft that would cap the receipt of any future incentive payments for qualifying participants that have received these bonuses for more than four years. Placing a five-year cap on the receipt of Advanced APM incentive payments would essentially render any APM entity that participated in the program starting in 2020 from receiving these incentives moving forward. In addition, there is a lack of clarity surrounding the operational aspects of implementing this cap, including whether the four years needs to, in fact, be consecutive. The AMA believes it is unwise to try and enact

such a drastic, retroactive change to the Advanced APM program via a bill that is largely designed to ensure crucial incentive payments are temporarily extended and could have the unintended impact of stifling greater movement towards value-based care models.

PRIOR AUTHORIZATION/MEDICARE ADVANTAGE PLANS

Prior authorization, or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment remains a principal frustration for physicians and jeopardizes patient care. According to a 2022 AMA survey, physicians complete an average of 45 prior authorizations per week, an administrative burden that consumes nearly two business days of physician and staff time.[5] The burden has become so acute that 35 percent of physician survey respondents hired staff to work exclusively on prior authorization requirements and 88 percent of respondents described this burden as either "high" or "extremely high."[6] These results came from a survey of 1,001 physicians practicing in the United States who provide at least 20 hours of patient care per week and complete prior authorizations during a typical week.[7]

While this utilization management technique is overused, costly, opaque, and burdensome to physicians, it is also harmful to patients due to the fact that it delays patient care. In fact, 33 percent of physicians who participated in the 2022 AMA survey reported that prior authorization led to a serious adverse event, such as hospitalization, disability, permanent bodily damage, or even death, for a patient in their care.[8]

In addition, research from the federal government demonstrates that prior authorization leads to delays in patient care and inappropriate denials of medically necessary services. A 2018 report from the HHS Office of Inspector General (OIG) concluded that, between 2014 and 2016, MA plans overturned 75 percent of their own prior authorization and payment denials when appealed by providers and beneficiaries.[9] An April 2022 HHS OIG report also found that 13 percent of prior authorization requests denied by MA plans met Medicare coverage rules and 18 percent of payment request denials met Medicare and MA billing rules.[10]

As a result, the AMA remains a strong supporter of the "Improving Seniors' Timely Access to Care Act." While this bill passed the House of Representatives in 2021 during the 117th Congress and the Ways and Means Committee passed this legislation as part of H.R. 4822, the "Health Care Price Transparency Act of 2023," we applaud the House Energy and Commerce Committee for reviewing this bill as part of the legislative hearing. Introduced by Representatives Suzan DelBene (D-WA), Mike Kelly (R-PA), Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN), at its core, the "Improving Seniors' Timely Access to Care Act" seeks to simplify, streamline, and standardize the prior authorization process within Medicare Advantage. More specifically, the bill mandates that MA plans implement electronic prior authorization programs that adhere to new standards adopted by the federal government. This will help ensure that physicians are no longer forced to resort to faxes and e-forms, or even disparate, proprietary portals that fail to comply with these newly developed standards. In addition, the bill's provisions requiring robust data reporting, such as the number and percentage of prior authorization requests approved, denied, or approved upon appeal, will bring much needed transparency to ensure MA prior authorization programs are not inappropriately denying medically necessary care to patients and overburdening physicians with unnecessary requirements.

---

[5] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.
[10] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

The AMA also remains supportive of the section of the legislation mandating MA plans issue faster prior authorization decisions as it will help improve patient health care outcomes and better stewardship of scarce Medicare resources. The requirements for health plans to provide real-time prior authorization decisions for routinely approved services, as defined in implementing regulations, will help ensure that patients receive the care they need without delay. We also support that the bill directs MA plans unable to meet the real-time processing requirement in the event of "extenuating circumstances" to issue final prior authorization decisions within a 72-hour and 24-hour timeline for regular and emergent services, respectively. Notably, the legislation requires MA plans to report the number of prior authorizations subject to this exception, providing the transparency needed to deter abuse of this provision.

Furthermore, we support the section of the legislation requiring more timely prior authorization decisions for all other services within Medicare Part C. Requiring MA plans to issue final decisions within 24 hours for emergent services and no later than seven days after receipt of regular prior authorization requests is a vast improvement over current MA program practices.

Last Congress, a flawed $16 billion Congressional Budget Office (CBO) score prevented the legislation from receiving Senate consideration and ultimately being passed into law.[11] The House Energy and Commerce Committee's consideration of this legislation in the 118th Congress brings us one step closer to enacting this bill legislatively.

It is important to note that many of the same reforms that were included in the "Improving Seniors' Timely Access to Care Act" are also under consideration in an electronic prior authorization proposed regulation that was released in December 2022 by CMS.[12] This comment period for the proposed rule closed in March 2023 and physicians are still awaiting the release of the final regulation. If the final prior authorization regulation includes a mechanism for issuing real-time decisions, requirements to complete emergency requests within 24 hours, and detailed transparency metrics, these policies must, in turn, be incorporated into CBO's baseline estimate for the legislation. In other words, incorporation of these policies could potentially lead to the $16 billion cost estimate being substantially lowered.

Thankfully, Congress is on record in support of the Biden Administration finalizing the regulation in a manner that mirrors the pending legislation. In June 2023, Senators Sherrod Brown (D-OH), Roger Marshall, MD (R-KS), Kyrsten Sinema (I-AZ), and John Thune (R-SD), as well as Representatives DelBene, Kelly, Bera, and Bucshon led a letter to HHS and CMS pushing for the pending electronic prior authorization regulation to include these three crucial policies found in the "Improving Seniors' Timely Access to Care Act."[13] The letter, which was ultimately cosigned by 61 Senators and 233 members of Congress, requests a final regulation to include: 1) a mechanism for real-time electronic prior authorization decisions for routinely approved items and services; 2) requirements that plans respond to prior authorization requests within 24 hours for urgently needed care; and 3) detailed transparency metrics. Even if the regulation is ultimately finalized with these three policies, we applaud Energy and Commerce for considering this legislation as it will codify these concepts into law. Enactment of this legislation will undoubtedly help mitigate some of the negative effects of prior authorization.

While the "Improving Seniors' Timely Access to Care Act" focuses on improving the processes pertaining to prior authorization, other bills that are more centrally focused on limiting the use of this

---

[11] https://www.cbo.gov/system/files/2022-09/hr3173_0.pdf.
[12] https://www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient protection-and-affordable-care-act-advancing-interoperability.
[13] https://www.brown.senate.gov/imo/media/doc/senate_ma_pa_letter_to_cms_62123finalmerged.pdf.

utilization management technique should also be expeditiously considered by Congress. For example, the AMA supports H.R. 4968, the "Getting Over Lengthy Delays in Care as Required by Doctors (GOLD CARD) Act of 2023."

Introduced by Representatives Michael Burgess, MD (R-TX) and Vicente Gonzalez (D-TX) and referred to the House Energy and Commerce Committee, this bill amends the Social Security Act to exempt qualifying physicians from prior authorization requirements imposed by MA plans. The GOLD CARD Act of 2023 would exempt physicians from MA plan precertification requirements so long as 90 percent of the physicians' prior authorization requests were approved in the preceding twelve months. Services that are initially denied and pending appeal for at least 30-days are required to be considered approved with respect to the 90 percent threshold. The gold cards issued by MA plans would be applicable only to items and services (excluding pharmaceuticals) and remain in effect for at least one year. Although permitted to rescind the exemption, MA plans must demonstrate that less than 90 percent of the claims submitted during a 90-day plan period would not have received prior authorization. This 90-day lookback period must be extended until at least 10 claims are ultimately provided. In addition, the threshold also excludes any service that receives a change in coverage determination mid-year from the 90-day lookback period.

Finally, the legislation sets up a process that protects physicians from inappropriate rescissions of the gold cards. MA plan physicians who review the potential gold card rescissions are required to be actively engaged in the practice of medicine in the same or similar specialty as the physician under review, have knowledge about the specific service in question, and possess a current, nonrestricted license in the same state as the furnishing physician. Plus, physicians can appeal any attempt to rescind the exemption.

We urge the Energy and Commerce Committee to review and pass this legislation as soon as possible. Advancing the Improving Seniors' Timely Access to Care Act and the GOLD CARD Act will play a tremendous role in reducing the overarching burden of prior authorization on America's physicians.

PAYMENT DIFFERENTIALS BETWEEN HOSPITAL OUTPATIENT DEPARTMENTS AND PHYSICIAN PRATICES STEM FROM INADEQUATE MEDICARE PHYSICIAN PAY

Patients receive outpatient medical services in a variety of settings, including physician offices, hospital outpatient departments (HOPD) and ambulatory surgical centers (ASCs). With some exceptions, payment rates for outpatient services furnished in hospital facilities are higher than rates paid to physician offices or ASCs for providing the same service. The scope of the payment differential varies, depending on the service or procedure.

Payment differentials between HOPDs and independent physician practices stem from several factors, but most notably from inadequate Medicare physician payment rates. As mentioned above, Medicare physician pay has barely budged over the last two decades, increasing just 9 percent from 2001 to 2023, or just 0.4 percent per year on average. In comparison, Medicare hospital pay has increased roughly 70 percent between 2001 and 2023, with average annual increases of 2.5 percent per year for inpatient services and 2.4 percent for outpatient services. Notably, the cost of running a medical practice has increased 47 percent between 2001 and 2023, or 1.7 percent per year. Unlike nearly all other Medicare providers, physicians do not receive an annual inflationary payment update. When adjusted for inflation, which has been at levels not seen since the 1980s, Medicare physician pay has declined 26 percent from 2001 to 2023, or by 1.3 percent per year on average. CMS projects the increase in the costs to run a medical practice will be 4.5 percent next year but at the same time, physicians face a 3.36 percent reduction to the Medicare conversion factor in 2024.

These divergent payment updates put physicians at a significant disadvantage. Physicians who own and practice in independent offices must compete with HOPDs for the same clinician and non-clinical staff, equipment, and supplies, yet physician payments have failed to keep pace with inflation. Higher payments to HOPDs are also likely to incentivize the sale of physician practices to hospitals.

Achieving site-neutral payments for outpatient services and procedures will require increases in Medicare physician payment, so that practices can be sustained, and patient choice of care setting is safeguarded. Many policy proposals over the years have recommended simplistic, across-the-board solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting (i.e., lowering all services in the HOPD to MPS rates). However, shrinking payments to the lowest amount paid in any setting does not help physicians. The AMA does not believe it is possible to sustain a high-quality health care system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. As a result, the AMA advocates strongly that Congress allocate additional funds into the Medicare physician payment system to address increasing physician practice costs. **Specifically, the AMA and organized medicine strongly support H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," and urges Congress to provide physicians with much needed fiscal stability by passing this legislation, which provides an inflation-based payment update based on the Medicare Economic Index.**

HEALTH CARE WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

There is a projected shortage of between 54,100 and 139,000 physicians by 2033 on top of this 17,396 providers are needed to eliminate current primary care Health Professional Shortage Areas. This is particularly alarming since it is projected that there will be about a quarter fewer rural physicians practicing by 2030. In order to help curtail this shortage **more residency positions should be created**. "Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training."

In order to encourage more individuals to become physicians and to practice in areas that are most in need we recommend that:

- Congress should act to allow the cap on GME slots to be increased as needed to meet the nation's changing needs rather than remain stagnant. Also, the cap building period should be increased.

- The immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government. Moreover, the Teaching Health Center Graduate Medical Education, Rural Residency Planning and Development Programs, the National Health Service Corps, and the Indian Health Service should have their funding increased to bolster scholarships, loan forgiveness, and expand these programs.

- Support should be provided so that more institutions are incentivized to create rural training track programs.

- Holistic changes to how physicians are recruited need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical

school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound diverse clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural or underserved areas, support systems are needed.

To help alleviate the current and impeding physician shortage we strongly support:

- H.R. 2389/ S. 1302 the "Resident Physician Shortage Reduction Act," which would increase Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots.

- H.R. 4942/ S. 665 the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, as well as expand the total number of waivers available per state and make other targeted improvements to the program.

- H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act," bipartisan legislation that permits borrowers in medical or dental internships or residency programs to defer their student loans until completion of their educational training.

- H.R. 2761/ S. 705 the "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act," would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.

- S. 1403/ H.R. 3046 the "Medical Student Education Authorization Act," would reauthorize the MSE Program which provides grants to expand or support graduate education for physicians.

- Legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities. This would simultaneously achieve the important goal of diversifying the physician workforce in terms of economic background and geographic representation.

- Physician Shortage GME Cap Flex legislation, which would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages.

PHYSICIAN-OWNED HOSPITALS: IMPROVE COMPETITION AND QUALITY

The U.S. health care system is a market-based system that is not working as well as it could; it faces issues such as high and rising prices, suboptimal quality of care, and poor pricing practices.[14] This is partly the result of significant consolidation occurring in hospital markets around the country.[15] Many

---

[14] Martin Gaynor, *Antitrust Applied: Hospital Consolidation Concerns and Solutions*, Statement before Subcommittee on Competition Policy, Antitrust, and Consumer Rights subcommittee of U.S. Senate, 117th Cong. 6, 2 (May 19, 2021) (Martin Gaynor, *Antitrust Applied*).
[15] Martin Gaynor, *Antitrust Applied*, at 2; Emily Gee, *The High Price of Hospital Care*, Center for American Progress https://www.americanprogress.org/issues/healthcare/reports/2019/06/26/471464/high-price-hospital-

markets are now often dominated by one large, powerful health system, e.g., Boston (Partners), Pittsburgh (UPMC), and San Francisco (Sutter).[16] Consolidation has real-life consequences, as clearly laid out in a recent book by Professors David Dranove and Lawton R. Burns about health care "megaproviders."[17] They found that in markets "where megaproviders dominate…, health care spending is higher, often much higher, and health care quality is no better, and sometimes lower."[18] Given that hospitals account for over 31 percent of total health spending, hospital market concentration is a leading cause of America's high health care cost.[19] Moreover, hospital market concentration is fast becoming a problem for which antitrust provides little prospect for relief.[20] The AMA is focused on this issue because this consolidation drives up health care costs and marginalizes physicians who want to remain independent.[21]

Consolidation is Driving Increased Health Care Costs

Increased levels of hospital market concentration are shown to lead to increased health care costs.[22] One study found that "prices at monopoly hospitals are 12 percent higher than those in markets with four or more rivals."[23] Another earlier study found that hospital mergers that occur within the same market led to, on average, a 2.6 percent increase in hospital prices; mergers also resulted in increased hospital spending and reductions in wages.[24] Other research has found that hospital mergers result in prices that are 10 to 40 percent higher than pre-merger.[25] These effects also endure; after a merger, hospital prices generally continue to rise for at least two years.[26] Advocates for mergers argue that these mergers will be able to provide better care or lower costs; however, larger health care systems generally have neither superior health outcomes nor lower costs.[27] Even if there are savings associated with hospital consolidation, they are typically not passed onto consumers.[28] Competition, not consolidation, has been proven an effective way to save lives without raising health care costs.[29] Many of the witnesses testifying before the House

---

care/. (Accessed March 16, 2023), Martin Gaynor and Robert Town, *The Impact of Hospital Consolidation-Update, the Synthesis Project*, Robert Wood Johnson Foundation (June 2012).

[16] Martin Gaynor, *Antitrust Applied*, at 2.

[17] David Dranove and Lawton R Burns, *Big Med: Megaproviders and the High Cost of Health Care in America*, 178 (2021).

[18] Dranove, *supra,* at 178.

[19] Martin Gaynor, *Antitrust Applied*, at 5.

[20] Dranove, *supra,* at 178.

[21] Dranove, *supra,* at 178. The consolidation may also lead to enhanced hospital monopsony power in labor markets. Martin Gaynor, *Antitrust Applied* at 3.

[22] Martin Gaynor and Robert Town, *supra*.

[23] Zack Cooper, Stuart V Craig, Martin Gaynor, John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 The Quarterly Journal of Economics 1, 51 (February 2019). https://academic.oup.com/qje/article-abstract/134/1/51/5090426?redirectedFrom=fulltext.

[24] D. Arnold and C.M. Whaley, *Who Pays for Health Care Costs? The Effects of Health Care Prices on Wages,* RAND Corporation, 3 (2020).

[25] Martin Gaynor, *Health Care Industry Consolidation*, Statement before the Committee on Ways and Means Health Subcommittee of the U.S. House of Representatives, 107th Cong. (September 9, 2011).

[26] Martin Gaynor, *Antitrust Applied*, at 4.

[27] Patrick S. Romano and David J. Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 International Journal of the Economics of Business 1 (2011); Robert Lawton Burns, Jeffrey S. Mccullough, Douglas R. Wholey, Gregory Kruse, Peter Kralovec, and Ralph Muller. *Is the System Really the Solution? Operating Costs in Hospital Systems,* 72 Medical Care Research and Review 3, 247 (2015). doi:10.1177/1077558715583789.

[28] Emily Gee, *Provider Consolidation Drives Up Health Care Costs*, Center for American Progress, (last accessed July 14th, 2021), https://www.americanprogress.org/article/provider-consolidation-drives-health-care-costs/.

[29] Martin Gaynor, Rodrigo Moreno-Serra, and Carol Propper, *Death by Market Power: Reform, Competition, and*

Ways and Means Health Subcommittee echoed these views.

Increased Hospital Concentration is Correlated with Worse Health Outcomes

Beyond increased costs, greater hospital market concentration has been shown to lead to worse health outcomes for patients. Antitrust policy in health care markets has a role to play in reducing the growth of disparities in health care access.[30] For example, in one study mortality rates after heart attacks were found to be higher, by a statistically significant measure, in more concentrated markets.[31] Another study found correlation between increased mortality rates for patients with heart diseases and higher hospital market concentration.[32] Preventing consolidation reduces costs; but more importantly, it leads to superior health outcomes for patients.

Antitrust Enforcement has Not Been Adequate to Reinvigorate Markets

Antitrust enforcement has not been able to sufficiently restore competition in hospital markets. Professors Dranove and Burns conclude that "antitrust agencies have taken a go-slow approach to enforcement, reflecting a combination of risk aversion, resource limits, and rules of the legal system."[33] The antitrust response has been inadequate, notwithstanding the significant resources dedicated to restoring competition in health care. For example, between 2010 and 2018, over half of antitrust cases brought by the FTC were focused on the health care industry.[34] Yet, antitrust policy makes enforcement difficult. For example, many mergers are too small to require reporting to antitrust agencies. This allows hospitals to expand piecemeal and without supervision. Similarly, the FTC cannot take action against anticompetitive conduct by not-for-profit entities; this presents a significant problem, considering how many hospitals are run as not-for-profits.[35] Consequently, the problem of concentrated hospital markets dominated by mega-providers driving up the cost of health care in the United States requires new remedies.

Congress Should Lift the Ban It Placed on Physician-Owned Hospitals

Fortunately, there is something Congress can do. Low-hanging fruit would be passing H.R. 977/S. 470, the "Patient Access to Higher Quality Health Care Act of 2023" in order to remove a crucial barrier to health care market entry that Congress itself erected. This bipartisan, bicameral legislation permanently eliminates the near prohibition the Affordable Care Act (ACA) placed on Physician-Owned Hospitals (POHs). As explained by Joshua Perry, in *An Obituary for Physician-Owned Specialty Hospitals*, 23 Health Lawyer 2, 24 (2010), prior to the enactment of the ACA, physicians enjoyed a "whole hospital exception" to the Stark law—meaning that if they had an ownership interest in an entire hospital, and were authorized to perform services there, they could refer patients to that hospital. However, provisions within section 6001 of the ACA (42 U.S.C. 1395nn) essentially eliminate the Stark exception for physicians who do not have an ownership or investment interest and a provider agreement in effect as of December 31, 2010. Second, under current law the POH cannot expand its treatment capacity unless certain restrictive exceptions are met. Thus, the ACA all but put an end to one source of new competition in hospital markets by banning new POHs that depend on Medicare reimbursement.

Patient Outcomes in the National Health Service, 5 American Economic Journal: Economic Policy 4, 134 (2013). doi:10.1257/pol.5.4.134.

[30] Town, et al., *supra,* at page 10.
[31] DP Kessler and MB McClellan, *Is Hospital Competition Socially Wasteful?,* 115 Q J Econ. 2, 577 (2000).
[32] T.B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 Health Services Research, 1008 (2012).
[33] Dranove, supra, at 178.
[34] Martin Gaynor, *Antitrust Applied*, at 17.
[35] Martin Gaynor, *Antitrust Applied*, at 18.

A 2020 report from Alexander Acosta, Alex M. Azar II, and Steven T. Mnuchin entitled, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020), recommends that "Congress should consider repealing the ACA changes to physician self-referral law that limited physician-owned hospitals."[36] Congressional action would be especially welcome because **POHs have developed an enviable track record for high quality and low-cost care**.[37]

Opponents of POHs argue that they tend to treat patients who are less severely ill and less costly to treat than patients treated for the same conditions in general hospitals. They misleadingly call this "cherry picking" which they ascribe to the physician owners. However, the evidence indicates that POHs do *not* cherry pick patients. For example, CMS studied referral patterns associated with specialty hospitals and concluded that it "did not see clear, consistent patterns for referring to specialty hospitals among physician owners relative to their peers."[38] CMS concluded "we are unable to conclude that referrals were driven primarily based on incentives for financial gain."[39] Importantly, new economic research supports those findings. It finds strong evidence *against* cherry-picking by physician owners.[40]

Unfortunately, the POH ban forecloses the benefits of integrated, coordinated care delivery observed in vertically oriented self-referral models.[41] Benefits of self-referral in integrated delivery models include "one-stop shopping," improved sharing of clinical information, and better care delivery experienced by consumers. Critically, the ban on POHs is the wrong policy prescription to address potential concerns with self-referral models. There are other policy recommendations that do not sacrifice the benefits of POHs.[42]

Reversing the ACA-imposed ban on new construction or expansion of existing POHs will both stimulate greater competition and provide patients with another option to receive high quality health care services. An April 12, 2021 *Health Affairs* article entitled, *Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals*, explains how.

Much of the U.S. hospital market lacks competition and restoring the whole hospital exception to the Stark law by enacting H.R. 977/S. 470 is the right prescription.

[36] Alexander Acosta, Alex M. Azar II, Steven T. Mnuchin, *Reforming America's Healthcare System Through Choice and Competition*, U.S. Department of Health and Human Services, U.S. Department of Treasury, U.S. Department of Labor (2020).
[37] *Id.*
[38] Study of Physician-owned Specialty Hospitals Required in Section 507(c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, pp 36-55 (2005) (CMS Report). Available at http://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/RTC-StudyofPhysOwnedSpecHosp.pdf.
[39] *Id.*
[40] Ashley Swanson. *Physician Investment in Hospitals: Specialization, Selection, and Quality in Cardiac Care.* 80 J Health Econ. (2021).
[41] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.
[42] Brian J. Miller, Robert E. Moffit, James Ficke, Joseph Marine and Jesse Ehrenfeld. *Reversing Hospital Consolidation: The Promise of Physician-Owned Hospitals*. Health Affairs (2021). Available at https://www.healthaffairs.org/do/10.1377/forefront.20210408.980640/.

FEWER BURDENS FOR BETTER CARE ACT

The AMA strongly supports the Fewer Burdens for Better Health Care Act and urges Congress to pass it. This bill would provide multi-stakeholder input on the removal of quality and efficiency measures from the Medicare program, which would help to ensure that the program is more efficient and effective for patients and physicians alike.

- November 1: CMS publishes list of measures being considered for addition *and removal*
- November 1: 30-day comment period begins, which is run by the consensus-based entity (CBE) (Battelle) to provide additional feedback for multi-stakeholder group consideration
- December - February: Multi-stakeholder group endorsement process, which wraps by February (as is current practice) – this part does not change, other than *requiring*, as opposed to just permitting, the CBE to consider measures to endorse for removal.

Shifting the timeline allows organizations, like AMA, the opportunity to provide more robust feedback on refining measures since it will move the process up, which currently conflicts with other measurers review processes in early December. Duplicative and antiquated administrative requirements need to be streamlined to ensure patient care is not being impeded by burdensome bureaucracy. The Fewer Burdens for Better Care Act gives providers a meaningful path to share how Medicare Quality Measures can be streamlined to improve the quality of care that patients receive.

SUNSHINE ACT

The AMA strongly supports the inclusion of important provisions of the Sunshine Act of 2023 (H.R. 9378), providing physicians with unrestricted access to the latest medical research and training materials to facilitate delivery of the best possible care. Inclusion of these measures rectifies a consequence stemming from a prior CMS practice of interpreting provisions of the Affordable Care Act to require that physicians report any continuing medical education events, as well as the distribution of medical textbooks and peer-reviewed journals, within the reporting scope. As a result, these educational resources became more challenging for physicians to obtain and hindered their ability to stay informed and updated. The noted Sunshine Act provisions, once enacted, will rectify this misinterpretation by exempting these crucial educational materials from reporting requirements. In so doing, negative impacts on physicians' access to up-to-date medical information will be minimized and providers' ability to provide the best care possible to their patients will be enhanced as a result.

CONCLUSION

The AMA is committed to working with the U.S. House of Representatives Committee on Energy and Commerce and Congress to find solutions that ensure that Medicare beneficiaries have access to high-quality, affordable health care. The AMA believes that the best way to achieve this goal is by reforming the MPS to make it more sustainable and equitable.