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Coalition of State Rheumatology Organizations

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

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

June 11, 2024

RE: CSRO Response to Committee White Paper entitled, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"

Dear Chairman Wyden and Ranking Member Crapo:

The Coalition of State Rheumatology Organizations (CSRO) is comprised of nearly every active state rheumatology society in the nation, representing over 40 states, with a mission of advocating for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist. We thank the Committee for its bipartisan interest in the topic of physician reimbursement. We offer several initial ideas for reform herein and would welcome the opportunity to discuss these in more detail.

We are particularly appreciative of the Committee's interest in leveraging physician reimbursement to improve chronic care delivery for Medicare beneficiaries. Rheumatologic disease is systemic and incurable, but innovations in medicine over the last several decades – primarily the development of biologics and biosimilars – have enabled rheumatologists to better manage these conditions. With access to the right treatment early in the disease, patients can generally delay or even avoid damage to their bones and joints, as well as reduce reliance on pain medications and other ancillary services, thus improving their quality of life. However, rheumatoid arthritis (RA) and other autoimmune conditions are extremely complex. Although rheumatology is beginning to benefit from more precise diagnostics, we still cannot predict with absolute accuracy which medication will work for a particular patient, because of RA's varied signaling pathways. Even where these tools are available, developing value-based care metrics or episode-based measures remains difficult. Within the confines created by these challenges, CSRO nonetheless continues to engage in efforts to define episodic care and appropriate cost measures.

For rheumatology and every other Medicare-heavy specialty, a major barrier to the exploration of additional value-based care initiatives is reimbursement instability in the Medicare Physician Fee Schedule and its downstream effects on reimbursements from Medicare Advantage plans. Practices with high numbers of Medicare beneficiaries are faced with a large and growing gap between their reimbursement and their costs, which leaves little to no room to invest in the systems and infrastructure that modern medicine demands or to incur the financial risk that many value-driven models require. For that reason, ***we urge the Committee to focus congressional efforts on several key policy areas that will provide immediate stability to the Fee Schedule, as described in detail below.***

I. Inflation Update

As the Committee highlights in its white paper, the Fee Schedule lacks a mechanism to incorporate inflationary increases into its reimbursement rates. That has created an ever-growing disconnect between the cost of providing care to Medicare beneficiaries and the program's reimbursement for that care. The medical community's endorsement of the Medicare Access and CHIP Reauthorization Act (MACRA) was rooted in the belief that it would replace the unpredictable Medicare payment landscape with a stable, quality-rewarding system. Unfortunately, this shift has not materialized as anticipated. According to the American Medical Association – and as noted by the Committee – reimbursement for Medicare physicians declined by 26% from 2001 to 2023, when one adjusts for inflation in practice costs. That is not a sustainable payment system and, inevitably, will lead to beneficiaries experiencing difficulty finding physicians who accept Medicare.

Currently, the functional cut resulting from the lack of an inflation update is compounded by the actual cuts resulting from budget neutrality and the ongoing Medicare sequestration, so that physicians face almost double-digit reductions. ***The Medicare Economic Index (MEI) provides the most relevant inflationary metric for medical practices, so we urge Congress to create a mechanism for MEI updates to the Fee Schedule***. Annually applying MEI is sensible policy in its own right, but it would also help mitigate reimbursement reductions called for by budget neutrality in years where such cuts occur.

II. Budget Neutrality

As the white paper describes, the Fee Schedule is subject to a statutory budget neutrality requirement, whereby increases in spending over a certain threshold must be offset by equivalent reductions in spending that same year. That threshold is $20 million, a level set by Congress in 1992 and never updated since. The Centers for Medicare and Medicaid Services (CMS) has no authority to change this statutory requirement, though its policy decisions have in the past "triggered" the threshold, thereby resulting in commensurate reimbursement reductions across the Fee Schedule. The concept of budget neutrality has turned the Fee Schedule into a fixed pie, while the outdated threshold amount will result in the threshold being triggered more and more as time goes by. The budget neutrality requirement is a main contributor to the annual pattern of Congress having to avert or mitigate reimbursement reductions at the end of the year. ***We urge Congress to apply annual MEI to the 1992 budget neutrality threshold to arrive at an appropriate current threshold, and to index the new threshold on a five-year basis from there.***

III. Practice Expense Data Input Updates

With regard to the Committee's questions related to RVUs, to minimize payment fluctuations, CMS must update data inputs on a routine basis. In 2022, CMS updated clinical labor practice expense (PE) inputs for the first time in two decades. Although that was a welcome update, the long delay meant that large increases were necessary to reflect twenty years of wage growth. That in turn triggered budget neutrality reductions once implemented. To avoid similar "shock waves" in the future, ***CMS must be directed to update data inputs on a more frequent and regular basis – ideally, every five years at a minimum.***

Additionally, the current valuation system is procedure-heavy, which does not always accurately reflect the cognitive work that is a critical component of chronic care. That is why CSRO has called for an expert panel to focus on cognitive services to supplement the work of the American Medical Association's Relative Value Scale Update Committee (RUC).

IV. Stop Extensions of Medicare Sequestration

After a temporary reprieve during the public health emergency, the 2% Medicare sequestration was fully phased back in as of July 1, 2022. When the Medicare sequester was first created, it was scheduled to occur from FY2013 through FY2021. However, Congress has since extended Medicare sequestration to pay for other priorities, so that it currently extends through FY2032 – a full decade past its originally envisioned end date. Extending the Medicare sequester to offset new spending exacerbates the long-term underfunding of the Fee Schedule. ***We urge Congress to reject any further extensions of the Medicare sequester.***

V. Unique Situation of Buy-and-Bill Part B Clinicians

The new Medicare Drug Price Negotiation Program (MDPNP) will become fully applicable to the pricing of selected Part B drugs in 2028, which is expected to result in large reductions to average sales prices (ASPs) for the selected medications. That in turn will result in reductions to reimbursement for the physicians who buy these medications at-risk for in-office administration, because reimbursement for selected drugs would be based on the maximum fair price (MFP) established via the MDPNP plus 6%, instead of the current ASP plus 6%. In either scenario, the actual reimbursement amount would be subject to the 2% Medicare sequester.

In the legislative process leading up to enactment of the MDPNP, several provider groups expressed concern that this program could have unintended consequences on the financial stability of practices who acquire medication for in-office administration. The legislation tried to guarantee the MFP price point for provider acquisition, but that guarantee will be difficult to operationalize in the complex world of drug acquisition with its layers of middlemen. If MFP-based reimbursement drops below acquisition costs for selected drugs, medical practices will suffer financial instability and may have to stop offering the selected drugs until acquisition costs can meet reimbursement levels. There is also a lack of clarity on the extent of the impact that MFPs will have on commercial ASPs and on the additional administrative burden that practices will have to incur to manage the different reimbursement rates for the same medication.

For these reasons, ***CSRO urges you to include the Protecting Patient Access to Cancer and Complex Therapies Act (S.2764) as part of comprehensive physician payment reform***. That legislation would leave intact the MDPNP process but would make changes to the mechanics of how Medicare obtains its savings. More specifically, the bill would remove Part B providers from the middle by requiring the drug manufacturers of selected drugs to reimburse Medicare directly for the difference between ASP and MFP on their selected products. Medicare would still obtain significant savings on Part B drugs and the bill would still guarantee beneficiaries access to MFP-based cost-sharing. This "best of both worlds" approach would keep in place the benefits of the MDPNP yet would also ensure that Part B providers are not inadvertently harmed in the process, ultimately protecting their Medicare patients' access to needed medication in the lowest-cost site of care.

VI. Alternative Payment Models (APMs)

The Committee includes several questions related to APMs, but there are no APMs in rheumatology. Additionally, rheumatologists struggle to join and meaningfully participate in Accountable Care Organizations (ACOs) due to the high cost of the medications used to manage rheumatologic and autoimmune conditions. Because rheumatologists have limited enrollment opportunities and because ACOs in some markets operate like "mini-insurers," ***CSRO urges Congress or CMS to establish "network adequacy" requirements.*** This would improve the likelihood that assigned beneficiaries have appropriate access and are referred in a timely manner for rheumatologic care, when necessary.

Thank you again for your interest in reforming Medicare physician reimbursement to improve chronic care delivered to Medicare beneficiaries. If you need additional information, please don't hesitate to contact us.

Sincerely,

Madelaine A. Feldman, MD, FACR
Vice President, Advocacy & Government Affairs