COLLEGE of AMERICAN PATHOLOGISTS

Statement for the Record

of the

College of American Pathologists

United States Senate Finance Committee

Re: The Collapse of Private Practice:
Examining the Challenges Facing Independent Medicine

June 4, 2024

Chairman Jason Smith
Ways and Means Committee
Washington, DC 20515

Ranking Member Richard Neal
Ways and Means Committee
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

The College of American Pathologists (CAP) appreciates the opportunity to share our views with the Committee regarding challenges facing independent medicine. As the world's largest organization of board-certified pathologists and leading provider of laboratory accreditation and proficiency testing programs, the CAP serves patients, pathologists, and the public by fostering and advocating excellence in the practice of pathology and laboratory medicine worldwide.

Although patients may never meet the pathologist on their care team, they can be assured that these physicians deliver quality patient care at every step. On any given day, pathologists in hospitals and private practices impact nearly all aspects of patient care, from diagnosing cancer to managing chronic diseases such as diabetes through accurate laboratory testing. Pathologists ensure laboratory quality so that diagnostic testing is safe and accurate. Often, they guide primary care and other doctors, determining the right test, at the right time, for the right patient. The influence of pathology services on clinical decision-making is pervasive and constitute a critical infrastructure and foundation of clinical medicine.

However, despite this critical role, pathologists are facing increasing pressures – both financial and regulatory/administrative – that threaten the financial viability of pathology practices and the ability of pathologists to provide care for patients. As a result, seventy-two percent of pathology practice leaders, according to the CAP's Practice Leader

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

Survey,[1] reported that their practice experienced a detrimental effect due to decreased reimbursement rates of pathology services over the last five years. For example, 35% reported an inability to fund an adequate number of pathologists and/or other laboratorians, 26% reported increased turn-around time for pathology reports, and 9% had to decrease or completely discontinue some on-site pathologist services at one or more hospitals.

Further, our members are seeing more examples of insurance companies dictating medical decisions with the primary goal of boosting revenue under the guise of controlling costs – and there is little pathology practices can do to combat this. As you know, the health insurance industry is a highly consolidated one, and in recent years insurers have increasingly flexed their market power to impose rate cuts and other burdens on pathologists. According to an American Medical Association (AMA) report on competition in health insurance, in 90% of metropolitan service area-level markets, at least one insurer had a commercial market share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.[2] Insurer consolidation and the instability within the health care marketplace more broadly is often cited as a reason for the merging/consolidation of physician practices. The goal being to gain negotiating power and respond to capital expenditures and other costs[3].

For pathology, the impact of these unstable market trends is illustrated in the CAP's Practice Leader Survey Report, in which about one-quarter of pathology practice leaders reported that their physician clients have been acquired by a corporation or health care system (26%), of whom 59% reported that the acquisition of their clients had a negative impact on their pathology practice.

At the same time, pathologists must also expend time and resources to meet billing and reporting requirements that are exacerbated by the Medicare Access and CHIP Reauthorization Act's (MACRA) incredible complexity. MACRA was originally passed to end a cycle of Medicare payment cuts and reward value-based care, yet today we are faced with continued financial instability within the Medicare physician payment system and value-based care that is not incentivized or attainable for most physicians. On top of that, consider the instability within the Medicare Physician Fee Schedule (PFS), numerous other state and federal rules, electronic health records and utilization management programs, and it is no surprise that there is a national burnout rate of more than 50 percent among physicians at a time when health care system is facing a critical shortage of physicians.

To ensure that physicians can remain in practice, we need to combat insurer consolidation and provide Medicare payments that are predictable and stable. It is imperative that Congress invest in physicians today and the workforce of tomorrow. Now

[1] Practice leaders are those in leadership or administrative roles with specific knowledge of the practice's financial, operational, and billing information.
[2] https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf
[3] https://www.healthcarevaluehub.org/advocate-resources/publications/addressing-consolidation-healthcare-industry

more than ever, patients should be able to rely on the expertise of pathologists and the availability of appropriate testing.

Combating Private Payer Challenges

Recently, our members have reported increasing requirements from insurers that result in fractured care, which by its nature disrupts health care quality and adds unnecessary burden for patients and their physicians. For example, insurers are increasingly steering patient care to preferred providers outside the hospital or health system, which prevents the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. As we recently explained to Horizon Blue Cross Blue Shield in New Jersey (Attachment 1), for patients who live further away from the health system/hospital, returning to receive care after the results have been returned may be difficult, and more likely to result in delayed care and compromised health outcomes. It should be up to the patient and their doctor to determine where diagnostic services occur, with the common goal of delivering the best outcome.

As this trend grows, it will likely lead to an overall increase in cost as cases will more frequently be requested for second review at the treating facility, which could lead to additional delays in care. We also have serious concerns about increasing prior authorization and utilization management policies that have the potential to inappropriately limit physician and other health care provider decision-making in the provision of patient care. As we explained to Wellmark[4] in Iowa and South Dakota, exclusion criteria will likely compromise establishment of the correct diagnosis in many cases.

Health insurance plans are also slashing reimbursement across the board – or ceasing reimbursement for critical services altogether – without any individual physician/practice consideration, leaving many pathologists in serious financial jeopardy. Blanket rate cuts that lower reimbursement below the cost to provide the services may benefit a select few laboratories and cut costs for the payer, but they threaten the financial viability of many smaller or rural laboratories and pathology practices. Furthermore, the recent Change Healthcare cyberattack is further straining resources and threatening private practices around the country.

Ensuring Sustainable Provider Financing

Inflationary Update

Over the last 5 years payments to pathologists have decreased by approximately 4.6 percent, while physician practice costs (medical supplies, lab personnel costs, professional liability insurance) have increased by nearly 13.8 percent. In 2024 alone, pathologists are anticipated to experience a net 5.7 percent reduction in Medicare Physician Fee Schedule reimbursement as payments are expected to fall by close to 1.1 percent while expenses are expected to increase by over 4.6 percent. The lack of an

[4] https://documents.cap.org/documents/Wellmark-Letter-v.3.pdf

annual inflationary update for pathologists, especially those that operate small businesses, compounds the wide range of shifting economic factors impacting the practice of pathology, such as increasing administrative burdens, staff salaries, office rent, and purchasing of essential technology when determining their ability to provide care to Medicare patients. The absence of an annual inflationary update, combined with the physician fee schedule's statutory budget neutrality requirements and ongoing Medicare payment cuts, further compounds the difficulties pathologists face in managing resources to continue caring for patients in their communities. **Therefore, the CAP requests that the Committee pass legislation to provide an inflationary update to the Medicare Physician Fee Schedule.**

Budget Neutrality

Budget neutrality is another barrier to achieving high-quality, high-value health care. These requirements lead to arbitrary reductions in reimbursement unrelated to the cost of providing care and lead to an unpredictable reimbursement system from year to year. The CAP acknowledges that budget neutrality is a politically appealing option to control rising health care costs. However, the CAP urges Congress to think more creatively and expansively about ways to manage health care costs which do not generate such significant instability for health care providers, threatening beneficiary access to essential health care services.

Because of the continuous reimbursement cuts caused by the physician fee schedule's budget neutrality requirements and the lack of an inflationary update, the cost of providing patient care is becoming unsustainable. As costs exceed revenues, laboratory workforce shortages will worsen, labs will close or consolidate, and/or pathologists will retire. The result: increased wait times in the emergency department, longer time before receiving a diagnosis of cancer, potential for increased errors in testing and delays in specimen collection and turnaround time for laboratory results and access to these critical services become further constrained. **Therefore, the CAP requests that the Committee pass legislation to eliminate, revise, or replace the budget neutrality requirements in Medicare.**

<u>Improving the Effectiveness of MACRA</u>

The cost and burden of participation in MIPS has been much higher than anticipated, particularly for small and/or rural practices, and the proposed upsides have been slow to materialize. Thus, within MIPS, the administrative and financial burden of participating far outweighs any marginal improvements in cost and quality that could possibly be ascribed to MIPS participation. The CMS's policies and the evolution of MACRA threatens single-specialty, community-based practices. As currently envisioned by the CMS, both MVPs and APMs significantly favor multispecialty practices, thereby encouraging consolidation.

Furthermore, while the CMS wants to see all Medicare beneficiaries and most Medicaid beneficiaries enrolled in an accountable care relationship by 2030, it is unclear how single-specialty, community-based practices can effectively participate in the CMS's

vision. The CMS has not explicitly articulated how this transition will occur, nor what they see as the primary accountable care relationship model for specialists. Finally, the underlying PFS has created significant financial instability for physician practices, and dissatisfaction with MACRA that may further discourage participation in value-based care models in the future. To that end, the CAP recommends the following to improve the effectiveness of MACRA:

- **Maintain meaningful quality measures.** The Centers for Medicare & Medicaid Services (CMS) is attempting to replace process measures: measures that look at whether the clinician did what he or she was supposed to do (example: annual hepatitis screening for active drug users) with outcome measures: what was the outcome of the procedure (example: decrease in lower back pain). Although pathologists do not have direct attributable control over the outcome of most procedures, and therefore do not have outcome measures, the importance of high-quality pathology in the process of care delivery is undeniable. Therefore, process measures have been and remain very important as a basis for ensuring quality health care and efforts should be taken to protect them.

- **Reduce the complexity of MIPS compliance and scoring.** Participating in MIPS is costly and burdensome. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks[5]. Congress should encourage innovation around solutions that minimize physician administrative, financial, and technological burdens of participation which do not improve the quality of patient care. CMS must work with stakeholders to assess burden-reduction mechanisms that acknowledge variability among different specialties. The technological burden of participation falls disproportionately on small and rural practices who may not have the resources to invest repeatedly in new technology[6]. CMS in conjunction with the Office of the National Coordinator for Health Information Technology (ONC) should utilize all available levers to increase access of practices and clinical data registries to hospital data to minimize the burden of reporting.

- **Preserve MIPS track and traditional reporting options.** The CMS should not sunset the traditional MIPS reporting option unless it can be clearly demonstrated that all clinicians are meaningfully participating in MVPs. Similarly, although MIPS was intended to be a temporary program as clinicians moved into APMs, the CMS should not sunset MIPS in favor of APMs until metrics show meaningful and complete APM participation.

- **Extend the APM bonus and APM participation requirements.** Without the incentive payment, providers will be less able to afford continued participation in Advanced APMs (considering operating costs and needed infrastructure) and

[5] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947

[6] https://www.rand.org/pubs/research_reports/RR2882.html

will be less likely to take on any new participation (given significant transformation investment costs). Not only does it appear this will further constrain pathologists' ability to participate in Advanced APMs but, like CMS, we are concerned about what this could do to "the availability and distribution of funds in the budget-neutral MIPS payment pool."

- **Require consideration of stakeholder input in APM development.** The CAP is concerned that models are being developed by Center for Medicare and Medicaid Innovation (CMMI) that dramatically change providers' clinical decision-making without considering the input of those specialties impacted by the model. Thus, the CAP has sought to ensure physicians, especially the societies that represent physicians participating in and affected by new payment models, have input into new model development. Additionally, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) provides an important opportunity for specialists to develop their own models and submit them for review and recommendation to the Secretary for Health and Human Services (HHS), yet CMMI has not tested as proposed any specialist-developed APMs recommended by the PTAC. More innovative payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models.

- **Reform the PTAC process.** The CAP is supportive of PTAC's role in the review and recommendation of payment models developed by physicians to HHS, particularly where specialists have not had the opportunity to participate in existing models. Specialists included in the models, though, should be consulted prior to model submission to ensure effective collaboration and to preserve and ideally improve the care of patients. When physicians are included in models submitted to the PTAC, but unaware of them, they cannot optimize care coordination for patients or support and encourage meaningful physician participation.

- **Prohibit mandatory APM participation.** The CAP understands that the concern over participation challenges inherent in voluntary models, but we strongly believe APM participation must be voluntary to avoid harmful consequences on physicians and their patients. For example, a Government Accountability Office report found that mandatory participation could negatively impact patient care and financial sustainability if participants are not able to leave the model. It also found that mandatory participation could impact organizations' ability to support other voluntary models for which they may be better equipped.

In short, private payer challenges, declining reimbursement, increased administrative and regulatory burdens continue to threaten the financial viability of physician practices. Declining reimbursement means not being able to cover the cost of services resulting in practice closures, consolidation, and/or retirement. Additionally, administrative, and regulatory burdens increase operating costs,

don’t improve patient outcomes, and force pathologists to spend more time on paperwork and less time providing necessary patient services. To that end, the CAP encourages the Committee to pass policies to reign in private payers, stabilize the physician fee schedule, and reduce regulatory burdens in MACRA. The CAP appreciates the opportunity to provide these comments for the record. Please contact Darren Fenwick at dfenwic@cap.org or 202-354-7135 if you have any questions regarding these comments.

Sincerely,

Donald S. Karcher, MD, FCAP
President

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

COLLEGE of AMERICAN PATHOLOGISTS

April 25, 2024

Sent via email

Denise O'Connor
Assistant General Counsel
Horizon Blue Cross Blue Shield of New Jersey

Eric Berman, MD
Chief Medical Officer
Horizon Blue Cross Blue Shield of New Jersey

Dear Ms. O'Connor and Dr. Berman:

On behalf of the College of American Pathologists (CAP), thank you and others at Horizon for taking the time to meet with us earlier this month. We appreciate your willingness to hear our concerns on behalf of our members and their patients. As we stated on the call, our interest is in ensuring insurer-imposed policies do not disrupt care coordination, add patient burdens, or compromise quality care. Unfortunately, we continue to see a number of these issues with recent actions by Horizon.

To start, we are still hearing from pathologists and practices in New Jersey – including since our call – expressing significant and genuine confusion over the recent changes. As you explained it to us, these changes are the result of Horizon's recent decision to enforce a policy that has been in effect since 2011. This "enforcement" is to ensure that, per the "Allowable Practice Locations for Pathologists" policy for managed care members, hospital-based pathologists are only "credentialed" and reimbursed for diagnostic services performed on patient specimens obtained in the hospital setting, and that all other specimens are sent to a "preferred" laboratory in the Horizon managed care network. While we acknowledge that Horizon recently revised the policy to provide additional clarity, these revisions have caused confusion in contrast to earlier Horizon policy language for providing pathology services "in a hospital setting." As such, the recent "enforcement" has been jarring. Independent laboratories and others also relied on earlier language in making changes to be in compliance.

Despite the assertion on the call that Horizon has not received any complaints, we know that pathologists and practices have reached out to Horizon for help but have not received calls back or information in return. **Thus, we urge you to address this communication breakdown and provide direct communication to impacted pathologists, including an overview of the policy and an explanation of the changes, and to provide an opportunity for pathologists and practices to ask questions and express their concerns.**

More importantly, the CAP calls on Horizon to reverse their recent decision to enforce this policy, so that clinicians can continue to choose local pathologists who are part of their model of coordinated care, which is an essential element in quality patient care. As we explained on the call, differentiating where specimens are sent, and which pathologists are "credentialed," based only on place of service results in

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100

fractured care that by its nature disrupts health care quality and adds unnecessary burden for patients and their physicians. In situations where the diagnostic biopsy leads to further hospital-based care (for example, an office-based fine-needle aspiration to diagnose cancer), the current requirement that patient samples be sent outside the local health system or care team prevents the local pathologist from participating in care coordination at the time of initial diagnosis or correlating these critical initial findings with subsequent surgical specimens obtained in the hospital. For patients who live further away from the health system/hospital, returning to receive care after the results have been returned may be difficult, and more likely to result in delayed care and compromised health outcomes.

Further, this requirement adds unnecessary time to treatment since it is typical, and often required, that the hospital-based pathologist confirm the diagnosis and assume responsibility for the patient's treatment. As acquiring outside materials can introduce significant delays in confirming diagnoses, patients may even require a second biopsy in the hospital setting to expedite care, which increases costs that may have been avoided. There are also logistical challenges and risks in dividing increasingly small diagnostic specimens to ensuring complete diagnostic and prognostic evaluation. Finally, some conditions may require rapid diagnosis for treatment (for example, small cell carcinoma) – not always possible when sending samples to outside laboratories – to prevent serious, even life-threatening complications. Pathologists impact nearly all aspects of patient care and are critical members of the health care team, from diagnosing cancer to participating in multidisciplinary conferences with the treating physicians (oncologists, surgeons, etc.) while the care plan is being formulated, to managing chronic diseases such as diabetes through ensuring accurate laboratory testing.

For these reasons, in addition to improved communication with impacted pathologists, we urge Horizon to reverse the recent decision to enforce this policy, and to revise it to support coordinated care for patients. Pathologists know that the right test at the right time makes all the difference for patients. The CAP is committed to improving care and addressing escalating health care costs, but disrupting care coordination can negatively affect a patient's diagnosis, treatment, and outcome. It should be up to the patient and their doctor to determine where diagnostic services occur, with the common goal of delivering the healthiest outcome.

Elizabeth Fassbender, JD, Director, Economic and Regulatory Affairs, is the contact person for further discussions. She can be reached at efassbe@cap.org or 608-469-8975. Thank you for engaging with us on this important issue.

Sincerely,

Ronald W. McLawhon, M.D., Ph.D., FCAP, FAACC
Chair, Economic Affairs Committee

College of American Pathologists
1001 G Street, NW, Suite 425W
Washington, DC 20001
202-354-7100