Statement for the Record

of the

College of American Pathologists

United States Senate Finance Committee

Re: Bolstering Chronic Care through Medicare Physician Payment

April 24, 2024

Chairman Ron Wyden

Senate Finance Committee

Washington, DC 20510

Ranking Member Mike Crapo

Senate Finance Committee

Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

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

As you are aware, pathologists are physicians who specialize in the diagnosis of disease. On any given day, pathologists impact nearly all aspects of patient care, from diagnosing cancer to managing chronic diseases such as diabetes through accurate laboratory testing. Often, they guide primary care and other doctors, determining the right test, at the right time, for the right patient. Pathologists in hospitals and independent laboratories around the country are also responsible for developing and/or selecting new test methodologies, validating, and approving testing for patient use, and expanding the testing capabilities of the communities they serve to meet emergent needs. Pathologists assure compliance with laboratory regulatory and accreditation standards, while preventing overuse or improper application of tests. Although patients may never meet the pathologist on their care team, they can be assured that these experts deliver quality and care at every step. Indeed, the influence of pathology services on clinical decision-making is pervasive and constitutes a critical infrastructure and foundation of appropriate care.

To help bolster the provision of chronic care services, the CAP recommends Congress work to stabilize the physician payment system, grow the health care workforce, increase oversight of insurer-imposed policies that impact patient care, and look at meaningful sources of health spending.

**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 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.**

A graph showing the cost of a health care system

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|  | **2020** | **2021** | **2022** | **2023** | **2024** | **5-Year Total** | **Yearly Average** |
| Pathology Medicare Payments | 0.03% | -1.75% | -0.65% | -1.16% | -1.11% | -4.64% | -0.93% |
| Medicare Economic Index (MEI) for Inflation | 1.9% | 1.4% | 2.1% | 3.8% | 4.6% | 13.80% | 2.76% |
| Difference | -1.87% | -3.15% | -2.75% | -4.96% | -5.7% | -18.44% | -3.69% |
| *Since 2020, reimbursement rates for pathology services have gone down by approximately 4.6%, while physician practice costs (medical supplies, lab personnel, professional liability insurance) have increased by nearly 13.8% over the same timeframe. In 2024 alone, pathologists are anticipated a net 5.7% reduction in Medicare Physician Fee Schedule reimbursement as payments are expected to fall by 1.1% while costs are expected to rise by 4.6%. Currently, it is too early to predict an MEI for 2025. Therefore, it is not included in above chart.* | | | | | | | |

**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, forcing physicians and other health care providers into adversarial roles, leading 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. 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. **Therefore, the CAP requests that the Committee pass legislation to eliminate, revise, or replace the budget neutrality requirements in Medicare.**

**Effectiveness of MACRA**

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.

There has been a chorus of dissatisfaction with the Merit-based Incentive Payment System (MIPS). The Medicare Payment Advisory Commission (MedPAC) has questioned the value of the MIPS program due to its design and measurement methods. Indeed, the Government Accounting Office’s (GAO) 2021 report on *Provider Performance and Experiences under the Merit-based Incentive Payment System* described many of the challenges physicians experience in the MIPS program, including the question of whether MIPS meaningfully improved quality of care or patient outcomes. It further indicated that the design of the program may incentivize reporting over quality improvement. CMS’s response to the GAO report was that a new pathway in MIPS, called MIPS Value Pathways (MVPs) would address many of these challenges. Unfortunately, both the MIPS and MVP quality programs continue to pose challenges, including for the care of chronic conditions. Alternative payment models (APMs) have similar issues, while the burden of data entry and other administrative requirements continue to impede the effectiveness of MACRA instead of improving care for patients.

1. **Quality Programs**

The MIPS and MVP programs incentivize silos of care rather than rewarding integration of the care team. Because CMS scores individual clinicians on quality measures that apply only to individuals, there is no incentive to foster collaboration. The proposed future of MIPS, MIPS Value Pathways or MVPs, exacerbate this problem because most current and proposed MVPs are specialty-specific rather than condition or procedure-specific. For instance, instead of a Melanoma MVP that includes quality measures for the entire care team (primary care clinicians, pathologists, dermatologists, Mohs’ surgeons, etc.), the Dermatological Care MVP includes quality measures for a variety of unrelated dermatological conditions. Thus, only dermatologists are eligible for this MVP and the disparate quality measures within it do not incentivize collaboration among dermatologists.

This problem is even worse for patients with chronic conditions who may require ongoing and episodic care; integration among the care team is even more important for these beneficiaries. However, the MIPS program only permits quality measures that cover a single calendar year, which does not align with how patients with chronic conditions experience care.

CMS should not remove or disincentivize process measures, especially for patients with chronic conditions. Since outcomes may be few and far between for these patients (e.g. diabetes will never be fully resolved for a patient), process measures are critical to ensure patients are receiving appropriate ongoing care. While we understand CMS’ desire to measure outcomes, under the belief that is what matters most to patients, for chronic conditions especially, process measures are critical.

Further, the CMS-proposed “upsides” of MIPS participation have not materialized, even for the highest performers. The seemingly promised 9 percent potential positive payment adjustments in return for flat PFS have not been realized and the cost and burden of participation in MIPS has been higher than anticipated. 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.

1. **Advanced Alternative Payment Model (APM)**

Within the APM track, there is an equivalent lack of meaningful results, with increased and unnecessary complexity built into the system. CMS recently acknowledged in its own *Synthesis of Evaluation Results across 21 Medicare Models, 2012-2020* that most of the current models created by the Center for Medicare and Medicaid Innovation (CMMI) are not meeting quality and savings goals. In fact, according to the CMS report only two APMs on CMS’s list of 21 improved the patient experience of care.

Additionally, despite there being hundreds of APMs, there have been very limited options for physicians to participate, much less for them to receive Qualifying APM Participant status from meeting the Advanced APM participation threshold. Per the recently released MedPAC data book (July 2022), most clinicians participating in Advanced APMs were in accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). In fact, of the clinicians who qualified for the 5 percent Advanced APM bonus, over 75 percent were in MSSP. Four other Advanced APMs made up most of the rest of the eligible clinicians, while just 3.4 percent participated in an Advanced APM other than the top four or MSSP. One look at the CMS website for available APMs, their associated rules, dates for sign-up, data reporting and other requirements, demonstrates an extraordinary amount of complexity for models that are hardly being utilized.

Further, many single-specialty practices are disenfranchised from being able to participate in APMs altogether. As currently envisioned by the CMS, APMs significantly favor multispecialty practices, including larger systems in urban settings. And 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 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. The CMS has acknowledged broad concerns among participants that the path to APMs remains unclear, particularly for specialties other than primary care. For example, of the Advanced APMs currently available, we believe pathologists are only able to participate in at most three models, and only to a very limited extent. Clearly, more opportunities are needed for specialty physicians to participate in Advanced APMs and incentives must recognize that high-value care is provided by both small practices and large systems, in both rural and urban settings.

1. **Reduce Health IT Administrative Burdens**

Another major barrier concerning implementation of MACRA is the associated administrative burden, particularly as it relates to the current state of health care data. While electronic health records are critical for advancing care accuracy, speed, and coordination, one size does not fit all with respect to health information technology (health IT). Even within a single specialty, different physician practices may have different levels of fluency with technology, and between specialties, maturity of health IT can vary widely. Therefore, when it comes to implementing the requirements of a system-wide program like MACRA, we suggest that regulations should acknowledge the varying states of data and encourage flexibility to accommodate different health IT readiness. Furthermore, rather than impose health IT requirements across the board, CMS and other agencies should work with stakeholders to move from the current state to an improved future state that promotes greater health data interoperability.

Data entry remains a major burden to complete implementation of MACRA, as it requires significant time and effort on the part of physicians and/or administrative staff, an average of more than 200 hours a year in one study[[1]](#footnote-1). However, one proposed alternative is quality measurement based on administrative claims. While these measures reduce data entry burden, they do not represent a complete fix; downsides of administrative-claims-based measurement include limited available data, retrospective evaluation, and oftentimes limited clinician control over the processes being measured. The CMS acknowledges the need for real-time evaluation and feedback, which cannot be accomplished with administrative-claims-based measurement.

The underlying PFS has created significant financial instability for physician practices, and dissatisfaction with MACRA may further discourage participation in value-based care models in the future. The long‐term consequence of failing to avert the cuts and improve the effectiveness of MACRA is decreased patient access to care. The CAP urges the Committee to improve the provision of chronic care services to patients by minimizing physician administrative, financial, and technological burdens of participation in MACRA. To further improve the effectiveness of MACRA and provision of chronic care, the CAP asks the committee to take the following actions:

1. Pass legislation to maintain meaningful quality measures. The 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). This is an issue for pathologists because there are not relevant outcome measures for pathology. Pathologists do not have direct attributable control over the outcome of most procedures. Process measures have been and remain very important in all aspects of health care and efforts should be taken to protect them.
2. Pass legislation to improve stakeholder participation in the development of new payment models. The CAP remains concerned that models are being developed by 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. Specifically, in carrying out its statutory duties of testing innovative health care payment and delivery models that lower costs while “preserving or enhancing the quality of care,” CMMI is required to consult clinical and analytical experts with expertise in medicine and health care management. Amongst those clinical experts and those with expertise in medicine and health care management, CMMI should be required to include associations representing physician specialties whose services are impacted directly in both primary and supporting roles by the Center’s models. Consultation with specialty associations will help ensure that models developed in a manner that is transparent and focused on the best interests of the patient consistent with sound clinical input and practices.

Additionally, the fact that CMS has yet to take up any of the models recommended by the Physician Focused Payment Model Technical Advisory Committee (PTAC) demonstrates the complexity in creating appropriate physician-developed APMs as envisioned under MACRA. Having physician input and buy-in is critical to effective delivery system reform. More innovative health care payment and delivery models must be developed in an open and transparent fashion with the input of those specialties impacted by the models.

1. Pass legislation requiring PTAC model submitters to consult participating and affected specialties prior to model submission. The PTAC provides an important opportunity for specialists to develop their own models and submit them for review and recommendation to the Secretary. However, at least three models submitted to the PTAC have included pathology services, yet the CAP was not consulted or even aware they encompassed pathology services until the models were posted for public comment. Model submitters should be required to provide evidence of consultation and concurrence from specialties participating in their models prior to submission so that the PTAC can make recommendations on models that are truly physician-focused and enable meaningful contribution of their participants in enhancing the care of patients.
2. Pass legislation requiring that traditional MIPS options be maintained for single specialty practices to ensure that private/independent practices of all sizes remain a viable option for physicians. Traditional MIPS, though burdensome, allows single specialty pathology practices to be accurately measured on relevant quality activities and obtain full incentives without pressure to consolidate. Many pathologists in independent practice choose to stay in MIPS for that reason. The CAP believes the replacement of traditional MIPS with MVPs and Advanced APMs incentivizes larger, multispecialty practices, as the clinical alignment envisioned by these programs is often achieved via physician employment or practice consolidation. Indeed, consolidation among physician practices and between hospitals and physician practices has accelerated in the past decade, with participation in APMs cited as reasons for consolidation[[2]](#footnote-2). This kind of consolidation is bad for ensuring access to quality care for patients in rural and underserved communities.

**Addressing the Health Care Workforce Shortage**

As you know, older adult patients require higher levels of care due to greater incidence of chronic disease, which will increase the demand for physician services on a smaller pool of available physicians. Therefore, it is imperative to grow the physician workforce. The Association of American Medical Colleges (AAMC) is projecting that the United States will face a shortage of up to 124,000 physicians by 2034. The CAP appreciates that Congress made a critical initial investment in the physician workforce by providing 1,000 Medicare-supported graduate medical education (GME) positions in the Consolidated Appropriations Act of 2021 and 200 Medicare-supported GME positions in the Consolidated Appropriations Act of 2023. However, these should be viewed as a down payment for a much larger documented need.

The demand for trained pathologists continues to far exceed the supply provided by the number of existing residency positions. Data from the CAP’s 2021 Practice Leader Survey is suggestive of a nationwide demand of 1,000-1,200 pathologists to fill open positions in the United States in recent years, and these numbers are substantially lower than the demand that is being reported for 2022. In contrast, over the last decade or so, there have been approximately 620 pathologist residency positions available each year. To meet the increased demand for pathologists and other physicians, there must be a larger investment in training. As such, the CAP asks the Committee to support the following bills:

1. Pass S. 1302, *The Resident Physician Shortage Reduction Act*. S. 1302 would provide 14,000 new Medicare-supported GME positions over seven years. While these 14,000 positions would not be enough to remedy the over 100,000 plus physician shortage, they are a critical step in the right direction. These positions would be targeted at hospitals with diverse needs, rural teaching hospitals, hospitals currently training over their Medicare caps, hospitals in states with new medical schools, and hospitals serving patients in health professional shortage areas.
2. Encourage committee members to support S. 665, *the CAP supports the Conrad State 30 and Physician Access Reauthorization Act*. S. 665 will increase the number of waivers for a state from 30 to 35 and incentivize qualified IMGs who are citizens of other nations to work in underserved communities. For agreeing to these terms, physicians will not have to leave the U.S. for two years before they are eligible to apply for an immigrant visa or permanent residence, thus allowing them to begin to provide necessary patient care in rural and underserved areas upon finishing their residency. IMGs are an important part of our nation’s health care system and currently represent 25% of the physician workforce.

**Insurer-Imposed Policies Impacting Patient Care**

Increasingly, our members are experiencing instances of improper practices by insurers, which has direct implications for patient care, including those with chronic conditions, and coverage. With the passage of federal legislation to address surprise billing, health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, and other providers to shift medically necessary health care costs onto their enrollees, which can be especially burdensome to those with multiple chronic conditions. For example, although it has made changes to the program, in 2021 UnitedHealthcare tried to roll out a “benefit design” that requires laboratories to meet UnitedHealthcare-determined efficiency and quality requirements to become a “Designated Diagnostic Provider” or DDP. Facilities that did not meet these requirements (non-DDP facilities) would “remain in network,” but UnitedHealthcare would not cover outpatient diagnostic laboratory services provided by these facilities, leaving patients “liable for charges.” Even with recent modifications, the CAP believes UnitedHealthcare policies that subject patients to an increased payment for services received at in-network, but non-DDP facilities, is counter to efforts to protect patients and eliminate surprise medical bills.

Other insurers are keeping facilities in-network but imposing restrictive referral requirements that result in fractured care and added burden for patients and their physicians. For example, in situations where a biopsy leads to further hospital-based care, requiring patient samples to be sent outside the health system either prevents participation of the pathologist who is part of the multidisciplinary team or adds a second physician to the diagnosis, as the hospital-based pathologist will have to confirm the diagnosis and assume responsibility for the patient. There are also logistical challenges and risks in dividing diagnostic material for a single patient. Further, these kinds of requirements can adversely affect appropriate response to acute developments in a patient’s care, and possibly cause significant delay in diagnosis. Some conditions may require rapid evaluation and treatment – not always possible when sending samples to outside laboratories – in order to prevent serious, even life-threatening complications. Additionally, 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 poorer health outcomes.

Finally, other health insurance plans are 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 across the nation. Blanket rate cuts that lower reimbursement below the cost to provide the services threaten the financial viability of many smaller and/or rural laboratories and pathology practices. And many pathologists have little leverage or ability to opt out-of-networks with powerful insurers because of consolidation and insurer control in their health systems and communities. Further, as the American Medical Association recently wrote to the FTC and Department of Justice, “mergers of market power health insurers tend to result in lower than competitive payments to health care providers, but there is no evidence the cost savings are passed through to consumers in the form of lower premiums.” Hindering access to high-quality pathology services through reduced rates or lack of payment for pathology and laboratory services, which adversely affects patient diagnosis, treatment, and outcomes.

Insurers’ increasing adoption of abusive practices and/or reliance on inadequate networks results in adverse consequences for access to quality patient care to benefit the financial interest of the payer. Now more than ever, patients – especially those with chronic conditions – and their treating physicians are relying on the expertise of pathologists and the availability of appropriate testing.

**Meaningful Sources of Health Care Spending**

Finally, the CAP realizes that the policies we are advocating for cost money. However, the health of our country’s citizenry, more than anything else, impacts all facets of our nation – from national security to its economic vitality, requiring significant financial investments. Therefore,

we encourage the Committee look at waste and consolidation in the health care system as a source potential source of revenue to stabilize the payment system and grow the workforce in lieu of site neutral policies. For example, the largest source of health care spending in the U.S. is administrative, with over $265 billion a year in waste according to some studies[[3]](#footnote-3). On the other hand, site neutral payment proposals fail to take into consideration the technical costs associated with specific individual codes and fail to recognize the distinct costs of physician services. Arbitrarily accepting hospital outpatient rates instead of the carefully reviewed inputs is a step backwards. The CMS has stated that comparisons between the physician fee schedule (PFS) and the out-patient prospective payment system (OPPS) payments for services are inappropriate because of the different nature of the cost inputs and has explicitly refused to impose one payment system on the other.

OPPS data is hospital data and does not reflect the actual resource costs of physicians in their offices or laboratories. It reflects the average costs of “buckets” of services rather than resource costs for individual services performed by physicians. The monies are then distributed by case-mix. Complete accuracy of this data is practically impossible. OPPS rate setting allows for meaningful comparison of resource-intensiveness and costs of services within the OPPS system. But the methodology is not designed to allow for comparisons to services outside the OPPS. Current law requires physician services to be resource-based and ambulatory payment classifications are not resource-based. In short, site-neutral proposals could result in billions of dollars being shifted between sites of service, and potentially out of the health care system, resulting in major disruptions in health care revenue at a time when consolidation is on the rise and practices in rural and underserved areas are struggling or closing.

In closing, 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,

/S/

Donald S. Karcher, MD, FCAP

President

1. Khullar D, Bond AM, O’Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum.* 2021;2(5):e210527.  [↑](#footnote-ref-1)
2. Medicare Payment Advisory Commission. 2022. March 2022 Report to the Congress: Medicare Payment Policy; Ch 4. Washington, DC: MedPAC [↑](#footnote-ref-2)
3. The Role of Administrative Waste In Excess US Health Spending, " Health Affairs Research Brief, October 6, 2022 [↑](#footnote-ref-3)