COLLEGE of AMERICAN PATHOLOGISTS

October 13, 2023

Sent to: hbcr.health@mail.house.gov

Dear Health Care Task Force Members:

Thank you for the opportunity to provide comments on steps Congress can take to improve health outcomes while lowering health care spending. 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. The expertise they provide drives treatment decisions that optimize outcomes for patients. They play an integral role in the diagnosis of diseases such as cancer (e.g., breast, prostate, cervical, leukemia, kidney), hepatitis, and cirrhosis. In general, pathologists in hospitals and independent laboratories around the country are 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 also assure compliance with laboratory, regulatory, and accreditation standards, while promoting the appropriate use of laboratory use in specific clinical situations. Pathology services are foundational to medical decision-making and appropriate clinical care.

The CAP agrees that serious and immediate improvements are needed to our nation's health care infrastructure. We believe that workforce challenges, increasing health care consolidation, and "patchwork financing models" contribute to access to care issues thereby worsening patient outcomes. As you know, physicians continue to be asked to do more with fewer resources each year, which simply does not reflect the needs of nor address the waste within our health care system. Therefore, we encourage the Committee to look at waste and consolidation in the health care system to fund and support some of the recommendations in this letter, rather than pitting physicians against each other, as in the current payment and quality systems, a fight where the ultimate losers are patients, who will have less access to care and suffer worse health outcomes, contrary to Congress's intent. For example, the largest source of waste in health care spending in the U.S. is administrative, with over $265 billion a year according to some studies. Addressing this huge overhead would reduce burdens and improve patient outcomes by enabling physicians to focus on treating patients.

Mitigate 2024 Medicare Cuts

As an initial matter, the CAP urges Congress to pass legislation before the end of the year to provide relief from the Medicare cuts scheduled to take effect in 2024. While Congress has previously taken action to address some of these fiscal challenges by mitigating some of the recent PFS cuts, payment continues to decline at a time when inflationary pressures mounting, increasing

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the cost of practices to operate. According to an American Medical Association (AMA) analysis, when adjusted for inflation, Medicare payments to clinicians have declined by 26% from 2001–2023. Further, a Medical Group Management Association report noted that a majority of practices surveyed (92 percent) said that 2022 Medicare reimbursement rates do not adequately cover the cost of care provided, and that nearly 60 percent of groups are considering limiting the number of new Medicare patients they accept, while 66 percent have considered reducing charity care. Additionally, they found that 58 percent of respondents said they might have to reduce the number of clinical staff and 29 percent are considering closing satellite locations, important areas of concern in providing health care in rural and underserved areas.

Finally, the PFS lacks an annual inflationary update, even though physicians, many of whom are small business owners, contend with a wide range of shifting economic pressures, such as increasing administrative burdens, staff salaries, office rent, and cost of essential technology necessary to provide care to Medicare patients. The absence of an annual inflationary update, combined with statutory budget neutrality requirements, further compounds the difficulties pathologists face in managing resources to continue caring for patients in their communities. As such, additional financial relief should be provided each year to provide crucial short-term financial stability until permanent, bipartisan payment reforms are enacted.

Sustainable Provider Financing

Effectiveness of MACRA

As you know, MACRA was originally passed to end a cycle of Medicare payment cuts caused by the SGR (Sustainable Growth Rate formula) and reward value-based care, yet today we are faced with continued financial instability in Medicare physician payments and value-based care that is not incentivized or attainable for most physicians.

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.

In the Advanced Alternative Payment Model (APM) track, there is an equivalent lack of meaningful results, with increased and unnecessary complexity built into the system. 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. 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. In addition, many single-specialty practices are disenfranchised from being able to participate in most APMs. Incentives for physicians to participate in Advanced APMs should recognize that high-value care is provided by both small practices and large systems, and in both rural and urban settings. Furthermore, most APM models created by the CMS Innovation Center (referred to as CMMI) are not extended beyond their initial demonstration period since they fail to reduce Medicare spending while maintaining quality of care. A recent study showed that in

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contrast to CBO estimates, the CMMI increased Medicare by $5.4 billion in its first ten years. Clearly the design and implementation of APMs requires re-evaluation to ensure reductions in cost are accomplished.

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. Per MedPAC's March 2022 report to Congress, increasing consolidation drives higher health care spending, at 2.8 percent average annual per patient growth from 2010 to 2020[1]. 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. The long-term consequence of failing to avert the cuts is decreased patient access to care.

Recommendations to Improve the Quality Payment Program

1. Pass legislation to extend the exceptional performance bonus pool for the MIPS program, which rewards the highest performers with additional funds, allowing them to continue providing the highest quality care. The CMS acknowledged in 2022 that "the statutory incentive structure under the Quality Payment Program for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians." Additionally, physicians have been reporting quality measures in the MIPS program for several years, but the available set of measures is constantly changing. This creates the illusion that the actions detailed in the quality measures are only important when physicians are not doing them; in fact, maintaining a high standard of quality is essential for patient safety and satisfaction. Physicians should be recognized and compensated for ongoing efforts to not only constantly improve but also constantly maintain that high level of quality, which requires significant effort from clinicians, administrative staff, and allied health professionals. Data from 2022 showed for the first time the potential of the MIPS program, with top scoring providers earning over an 8% positive payment adjustment. However, most of this adjustment came from the exceptional performance bonus pool, which has been exhausted. Therefore, clinicians who saw significant return on investment in 2022 (payment year 2024) may be disincentivized to participate when adjustments will likely drop significantly in 2023 (payment year 2025).

2. Pass legislation to maintain 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

[1] Medicare Payment Advisory Commission. 2022. Report to the Congress: *Medicare Payment Policy.* Washington, DC: MedPAC

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was the outcome of the procedure (example: decrease in lower back pain). This is an issue for pathologists because they do have outcomes measures. Pathologists are not responsible for the outcomes of a procedure. Process measures have been and remain very important in all aspects of health care. The CAP recommends that Congress create legislation recognizing the importance of process measures in promoting quality of care.

3. Pass legislation to extend and increase the Advanced APM Incentive Payment. Practices who have joined Advanced APMs undertake significant practice redesign activities to provide enhanced services to beneficiaries including 24/7 access to care, patient navigation, care planning, and more. Advanced APM participants also take on significant downside financial risk by participating, thereby demonstrating their commitment to value in health care. As with practices in MIPS, the burdens associated with these activities are significant. Specifically, the consequences of the loss of the APM Incentive Payment, which was a critical component in rewarding high-quality treatment of patients and in increasing participation in Advanced APMs, cannot be underestimated. Without the incentive payment, providers will be less likely to afford continued participation in Advanced APMs (considering operating costs and needed infrastructure) and will be less likely to take on any new participation (given significant transformation/investment costs). Therefore, the Committee should extend the Advanced APM Incentive Payment and increase it to 5 percent.

4. Pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act. On top of the scheduled cuts and sequester, physicians do not receive annual updates for inflation. While MACRA was an agreement between Congress and organized medicine that resulted in a frozen fee schedule in return for an upside potential with MIPS (mostly) and bonuses for Advanced APM participation, the upside potential under MIPS has been slow to materialize and incomplete, and Advanced APM participation remains extremely limited. To help reduce fiscal uncertainty and the ever-increasing financial burden of running a physician practice, Congress must end the statutory freeze in annual Medicare physician payments and provide updates based on the Medicare Economic Index (MEI) in 2023 and beyond.

5. Pass legislation to mandate stakeholder participation in the development of new payment models. The CAP remains concerned that models are being submitted to the Physician Focused Payment Model Technical Advisory Committee (PTAC) and 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," the CMMI is required to consult clinical and analytical experts in medicine and health care management. CMMI should also 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 are developed in a manner that is transparent and focused on the best interests of patients consistent with sound clinical input

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and practices. Furthermore, CMMI releases models independently of the usual regulatory process, meaning there is no opportunity for public comment on models. CMMI should be required to have a 60-day public comment period on all models before they are finalized.

6. Pass legislation requiring 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 of the Department of Health and Human Services. 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 show evidence of consultation and concurrence from specialties participating in their models prior to their 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.

7. Pass legislation requiring that traditional MIPS options must 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 obtain full incentives. Many pathologists in independent practice choose to stay in MIPS for this 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 a reason for consolidation[2]. This kind of consolidation is bad for ensuring access to quality care for patients in rural and underserved communities, especially given the high volume of hospitals in rural areas that have already closed[3].

Reform the Physician Fee Schedule (PFS)'s Budget Neutrality Requirement

To address sustainable provider financing, Congress must consider reforms to the budget neutrality requirement within the current PFS system. Indeed, budget neutrality is a major barrier to achieving high-quality, high-value health care as 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 and an unpredictable reimbursement system (clinicians cannot predict their reimbursement year after year, even if they maintain the same quality of care). As you know, the changes to the evaluation and management (E/M) codes in 2019 would have resulted in a 9 percent cut in reimbursement to all pathologists had Congress not intervened. This kind of excessive reduction to reimbursement and continued uncertainty prevents clinicians from making financial decisions or investing in innovation that is in the best long-term interests of their patients and the overall health care system. While we acknowledge that budget neutrality is an appealing

[2] Medicare Payment Advisory Commission. 2022. March 2022 Report to the Congress: Medicare Payment Policy; Ch 4. Washington, DC: MedPAC

[3] Data from a recent CAP survey shows that 44% of pathology practices provide services to hospitals or laboratories in rural areas.

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option to control rising health care costs, we encourage Congress to think more creatively and expansively about ways to manage health care costs that does not generate such significant instability for health care providers and threaten beneficiary access to essential health care services. For instance, policies focused on controlling administrative waste should be a higher priority than cutting physician reimbursement or furthering budget neutrality within the PFS.

Budget neutrality within MACRA (in particular, MIPS) also poses barriers to high-quality, high-value care as it encourages workarounds or "gaming" of the system rather than true improvements in quality and value, and it encourages clinicians to leave the program rather than compete with other physicians for a small pool of funds. Again, while we recognize that budget neutrality has been considered an important component of controlling costs within the health care system, imposing this requirement on individual clinicians does not address the real sources of waste in the system. Slightly higher Medicare reimbursement to MIPS-eligible physicians is simply not the main driver of increasing health care costs. **Therefore, the CAP asks that Congress pass legislation to eliminate, revise, or replace the budget neutrality requirements in Medicare.**

Health Care Workforce

As you are likely aware, 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. H.R. 2389, the Resident Physician Shortage Reduction Act. H.R. 2389 would provide 14,000 new Medicare-supported GME positions over seven years. While these 14,000 positions would not be enough to remedy the 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. Legislation that would reserve a certain number of Medicare-supported GME positions specifically for pathology. During the COVID-19 pandemic, pathologists have been on the frontline of the crisis, responsible for ensuring prompt and accurate testing for patients and

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health care providers alike. However, as workers leave the laboratory ecosystem, the strain felt by those who remain reaches a breaking point leaving pathologists unable to keep up with the demand for necessary and essential diagnostic services. The result can manifest in delays in patient care, including increased wait times in the emergency department or longer time before receiving a diagnosis of cancer. This, coupled with the fact that current demand for pathologists is being reported as more than double that of available residency positions per year, shows that there is a crucial need to increase pathologist residency positions. Therefore, the CAP urges Congress to craft and pass legislation that would reserve a certain number of Medicare-supported GME positions only for pathology.

3. H.R. 4942, the Conrad State 30 and Physician Access Reauthorization Act. H.R. 4942 would reauthorize the Conrad 30 waiver program for three years, make improvements to the program, and increase the number of waivers granted to each state from 30 to 35. This bill would also incentivize qualified international medical graduates (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.

4. H.R. 4875, the Doctors in our Borders Act. H.R. 4875 would increase the number of Conrad 30 waivers for a state from 30 to 100, and in turn help expand access to critical patient care in underserved communities.

5. H.R. 2761, the Specialty Physicians Advancing Rural Care (SPARC) Act. Rural and underserved areas continue to suffer the most from the health care workforce shortage. Unfortunately, there is not much of an incentive for pathologists who finish their residency to move to rural or underserved areas to practice. H.R. 2761 would establish a new loan repayment program designed specifically for specialty physicians, allowing them to practice in a rural area for six years in exchange for student loan forgiveness of up to $250,000.

6. H.R. 1202, the Resident Education Deferred Interest (REDI) Act. In addition to loan forgiveness, interest-free loan deferment, which would prevent thousands of dollars in interest from accruing, would make opening practices in rural or underserved areas more attractive and affordable to residents. Residents are often saddled with substantial student loans that they cannot immediately begin to repay. Should they choose to have their payments halted through deferment or forbearance during their residency, they would continue to accumulate interest. H.R. 1202 would allow physicians and dentists to defer their federal student loans interest-free during their residency or internship, saving them thousands of dollars in interest.

The CAP urges opposition of any legislation that would expand the scope of practice for non-physician practitioners (NPPs). While NPPs play an important role in providing care to patients and there are many technical specialties that support pathologists in their work, there are no alternative

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providers for pathologists and the value they provide. In short, allowing an increase in the types of services NPPs can perform is not a sensible solution to the health care workforce shortage and it could also have broad, negative consequences.

Innovative Models and Technology

Reduce Health IT Administrative Burdens

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. Specifically for rural health clinics, approximately 43% report the costs of health IT prevent their participation in accountable care organizations. This does not take into consideration the costs for laboratories in rural areas, which may have different health IT needs than rural health clinics.

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[4]. That same study showed that the mean annual per physician cost of participating in MIPS was $12,811 in 2019[4]. This cost includes some expenses associated with health IT such as software to report MIPS data to CMS. 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 challenges are even higher when viewed through the lens of rural health care; low volume for any given procedure or diagnosis means measurement can be unreliable and lead to skewed scoring and payment. However, low patient volume also disincentivizes investment in APMs due to less predictable spending patterns. Thus, relatively more rural providers remain in MIPS as compared to providers in urban areas.

The CAP urges the Committee to encourage innovative solutions that minimize physician administrative, financial, and technological burdens of participation that do not improve the quality of patient care. **To this end, the CAP suggests reducing the complexity of complying with MIPS and MIPS scoring and working with stakeholders to assess burden-reduction mechanisms that acknowledge variability among different specialties.**

[4] 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.

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In closing, the CAP appreciates the Committee's work in this space and the opportunity to comment. Please contact Darren Fenwick at dfenwic@cap.org / 202-354-7135 if you have any questions regarding these comments.

Sincerely,

Donald S. Karcher, MD, FCAP
President

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Suite 425 West
Washington, DC 20001
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