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1301 K Street NW, Suite 300W
Washington, D.C. 20005
(202) 309-0796

House Energy & Commerce Health Subcommittee: What's the Prognosis?: Examining Medicare Proposals to Improve Patient Access to Care & Minimize Red Tape for Doctors

EXECUTIVE SUMMARY

The House Energy & Commerce (E&C) Health Subcommittee convened a hearing to discuss a wide array of proposals to increase physician payment, increase access to care, and reduce administrative burden. Members spoke with two panels which included representatives from the Administration, physicians, the Medicare Payment Advisory Commission (MedPAC) and think tanks. This hearing was the first to examine physician payment reform in recent years and is a first step to addressing some longstanding issues. A brief description of each of the 23 bills is included at the end of this summary.

- **Political Landscape.** House Republicans continue to struggle to elect a new speaker, which has stalled forward progress on the floor and heightened political tensions. The hearing was put on hold after only a few representatives were able to ask questions of the first panel, and reconvened hours later with only the second panel. Democrats said that the hearing was rushed since many of the bills are still discussion drafts and were not provided early enough for bipartisan work or Democrat input even when they contain bipartisan policies.

  However, members were generally interested in proposals to adjust physician payment for inflation, adopt site neutrality, reduce prior authorization, and rethink the Quality Payment Program.

- **Next Steps.** Given other must-pass legislation that expired this year, it is unlikely that any of these proposals will be included in a health package this year. Instead, this hearing sets the groundwork for the Subcommittee's work next year and ongoing conversations about topics such as site neutrality, inflation, and Medicare Access and CHIP Reauthorization Act (MACRA) reform.

OPENING STATEMENTS

- **Chair of the Subcommittee Brett Guthrie (R-KY)** opened the hearing by emphasizing the need to drive high quality care while ensuring that Medicare remains solvent. Rep. Guthrie noted that this is the first hearing in several years to reexamine the physician reimbursement system.

- **Vice Chair of the Subcommittee Larry Buschon (R-IN)** said that the Subcommittee should ensure that providers are able to focus on providing patient care rather than administration or prior authorization. Rep. Buschon supported legislation to provide inflationary updates for physicians and to promote value-based care.

- **Ranking Member of the Subcommittee Anna Eshoo (D-CA)** expressed disappointment that the Subcommittee is not considering the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide inflationary updates to physician payment, and supported MedPAC's recommendation to eliminate the Merit Based Incentive Payment System (MIPS).

- **Chair of the E&C full committee Cathy McMorris Rodgers (R-WA)** emphasized the impact of inflation on Part B premiums and the cost of running an independent medical practice. Rep. Rodgers supported legislation to avert payment cuts, but also to make permanent changes to physician payment so that Congress does not have to avert cuts through legislation every year.

- **Ranking Member of the E&C full committee Frank Pallone (D-NJ)** criticized House Republicans for not being able to elect a speaker and move forward on important legislation. Rep. Pallone also criticized Republicans for including several bills that would increase Medicare spending by billions of dollars without identifying a source of funding, while simultaneously electing candidates for speaker who plan to make cuts to Medicare spending.

WITNESS TESTIMONY

Panel I

- **Dr. Meena Seshamani, MD, PhD, Director, Center for Medicare, Centers for Medicare & Medicaid Services** (testimony) testified that Medicare's goals are to provide high-quality whole-person care, improve access to care, advance health equity, and improve affordability and sustainability. Dr. Seshamani emphasized savings as a result of Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) and said that CMS is looking to move to more value-based care models.

- **Leslie Gordon, Director, Health Care, Government Accountability Office (GAO)** (testimony) summarized the key takeaways from three GAO reports over the last several years. The first report looked at the geographic payment adjustment and found that it accounted for variation in most counties but not all. The second and third reports looked at patient and physician experience with MIPS and Alternative Payment Models (APMs), showing that fewer providers participate in APMs.

- **Paul Masi, Executive Director, MedPAC** (testimony) summarized MedPAC's work on physician payment that has generally found payment to be adequate, but recommended that payments increase by half of the Medicare Economic Index (MEI) for 2024 and include an add-on for physicians who treat low-income patients. Masi also reiterated the recommendation to eliminate MIPS because it is burdensome and does not collect meaningful quality information.

Panel II

- **Dr. Steven Furr, MD, FAAFP, President-Elect, American Academy of Family Physicians** (testimony) testified that primary care practitioners are treating patients with increasingly complicated care needs, but have not received adequate support. Dr. Furr supported the CMS proposed G2211 add-on code for complex care and urged Congress to reform the budget neutrality requirement, include an update for inflation, support movement to value-based payment models, and reduce administrative burden from prior authorization and quality programs.

- **Dr. Debra Patt, MD, PhD, MBA, Executive Vice President, Texas Oncology** (testimony) said that the disparity in reimbursement between physicians and hospitals has fueled consolidation, and asked Congress to address payment cuts, provide an inflation update, pass site neutrality proposals, and fix 340B payments.

- **Joe Albanese, MPP, Senior Policy Analyst, Paragon Health Institute** (testimony) suggested policies to offset payment increases through lowering payment for Part B drugs and implementing site neutrality. Albanese also criticized both MIPS and APMs for costing money rather than saving money or improving quality, and said that Medicare Advantage is the best option to promote value.

- **Dr. Matthew Fiedler, PhD, Joseph A. Pechman Senior Fellow in Economic Studies, The Brookings Institution** (testimony) said that most Medicare beneficiaries do not currently experience issues with access to care and have reported equal or better access than individuals with private insurance. Dr. Fiedler supported structural changes to eliminate MIPS, maintain bonuses for participation in Advanced APMs, insulate physician payments from inflation shocks in a budget neutral manner, and adopt site neutral payments for ambulatory services.

DISCUSSION

Physician Payment

- **Rep. Eshoo asked how MedPAC recommends reducing overpayments in Medicare Advantage.** Masi responded that MedPAC recommends that the MA quality program be budget neutral, be restructured to collect more meaningful quality information, and that coding intensity be addressed.
- **Rep. Rodgers suggested that CMS look into other types of services that could be done in outpatient or lower cost settings to save money.** Dr. Seshamani said that CMS is continuing to analyze the data.

- **Rep. Michael Burgess (R-TX) asked how eliminating the budget neutrality requirement for physician fee schedule updates would support providers.** Dr. Furr said that the requirement puts providers in competition with one another because of the redistribution. Rep. Burgess introduced legislation earlier this week along with the House Doctors Caucus that would increase the budget neutrality threshold.

Access to Care

- **Several representatives argued that even though access to care has been relatively consistent even as payment decreased, lower payments are contributing to the workforce shortage which will worsen access.** Dr. Fiedler countered that it is possible that payment impacts access to care on the margins, but it is unclear whether increasing payments would have a meaningful impact on access to care since Medicare beneficiaries have equal or better access than individuals with private insurance. Rep. Eshoo said that anecdotal evidence shows that doctors are leaving the workforce because of pay, which was worsened by COVID-19, and that Medicare does not pay enough to support independent physician practices. Dr. Patt repeatedly said that lower physician fee schedule payments impact clinics' abilities to pay competitive wages, so they cannot be adequately staffed, which leads to issues with network adequacy and lower access to care or to consolidation.

- **Representatives from both parties strongly supported legislation to adjust physician payment for inflation.** Democrats in particular supported H.R. 2474, which was not included in this hearing.

- **Rep. Eshoo asked whether the geographic index is helpful for physicians.** Dr. Furr said that it is helpful because it can help address higher costs of delivering care in rural areas where patients are more likely to be low income and requested that Congress prevent the floor from being eliminated this year.

- **Rep. Pallone expressed disappointment that the Helping Low-Income Seniors Afford Care Act (H.R. 5360) was not included in the hearing, which would extend funding for outreach to lower**

income individuals to help them choose Medicare plans. Dr. Seshamani agreed that outreach is an important component of the Medicare program.

- **Rep. Robin Kelly (D-IL) asked what changes could be made to the fee schedule to improve access to care in rural areas.** Dr. Fiedler said that the CMS Innovation Center (CMMI) is working on incorporating rural providers into ACOs which could be beneficial and suggested targeting certain patient populations through the Medicare Savings Program (MSP).

Quality Measurement and Value-Based Care

- **Several Republicans questioned whether APMs and CMMI's models more broadly are effective.** Rep. Rodgers asked if APMs have been shown to improve the value of care and Albanese responded by noting the recent Congressional Budget Office (CBO) report showing that CMMI has cost money rather than saved money in its first ten years. Albanese supports population-based models in Medicare Advantage instead because he said they have shown successful savings which are required to be put into additional benefits or lower premiums. Rep. Guthrie asked how to ensure that CMMI is driving value. Dr. Patt said that practices need nudges to participate, and Dr. Fiedler agreed and added that CMMI has relied mostly on voluntary models which do not prioritize government saving. Dr. Fiedler suggested mandatory models or increased incentives. Albanese said that Congress should provide more oversight over CMMI. **Rep. Mariannette Miller Meeks (R-IA)** also noted that APMs do not have much engagement from specialists and have not been shown to be effective at saving money.

- **Rep. Guthrie asked panelists to discuss the differences between MIPS and APMs and why more clinicians participate in MIPS.** Gordon replied that eligible providers are required to participate in MIPS while participation in APMs is voluntary, and providers can face significant upfront costs to join APMs. In response to a similar question, Masi noted that it is important to give providers, especially at small practices, opportunities to transition to APMs with support.

- **Reps. Kim Schrier (D-WA) and Buschon supported their Value in Health Care Act (H.R. 5013) which was not incldued in this hearing but would extend the incentive payment for participation in APMs.** A discussion draft of legislation to extend the incentive was included in this hearing, but it would institute a retroactive five-year cap and provide a lower payment.

- **Regarding quality, Rep. Miller Meeks said that qualified clinical data registries are not being used to their full potential.**

Site Neutrality and Consolidation

- **Rep. Buschon and Rep. Rodgers asked whether the lack of site neutral payments impacts consolidation.** Dr. Patt said that when physicians are reimbursed at lower rates than hospitals, they cannot offer competitive wages and cannot stay open without consolidating. Albanese agreed that the lack of site neutral policies drives consolidation, and more site neutrality would save money for Medicare.
- **Several representatives suggested that the fact that hospitals receive payment updates for inflation but physicians do not has led to increased consolidation and fewer independent practices.**

- **Rep. Burgess voiced support for his bill that would allow physician-owned hospitals to be opened or expanded in rural areas, which he said could help prevent provider consolidation.**

Drugs

- **Representatives from both parties supported the Seniors' Access to Critical Medications Act (H.R. 5526) which would allow certain medications including oncology medications to be mailed to patients.** They criticized CMS for reversing its COVID-19 policy that allowed these drugs to be mailed by waiving the Stark Law prohibition on physician self-referral.

- **Rep. Guthrie pushed Dr. Seshamani on including rebates in determining the net price when CMS selects drugs for price negotiation.** Dr. Seshamani said that CMS is following the law as written and is prohibited from interfering with the negotiation process between pharmacy benefit managers (PBMs) and manufacturers.

Administrative Burden

- **Rep. Schrier emphasized that many members from both parties are still intending to pass the Improving Seniors' Timely Access to Care Act,** but they also encourage the Office of the National Coordinator for Health Information Technology (ONC) to swiftly finalize its proposed rules for interoperability and electronic prior authorization and health care attachments.

- **Rep. Dan Crenshaw (R-TX) asked about the administrative burden of reporting requirements in APMs and MIPS**. Dr. Patt said there is a significant burden for both programs, but APMs also allow for investment in patient care. Albanese said that MIPS greatly increases administrative burden without documented results for improved care.

- **Representatives asked for suggestions for how to reduce the administrative burden.** Dr. Furr suggested standardized quality measures across CMS programs and private insurance since each

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plan has its own measures and plans sometimes collect the same measures in different ways. Masi, Dr. Fiedler, and Albanese agreed that MIPS should be eliminated.

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INCLUDED LEGISLATION

Provider Payment Rates

- H.R.___, **the Provider Reimbursement Stability Act of 2023** – This bill would increase the budget neutrality threshold for the PFS from $20,000,000 a year to $53,000,000 for 2025 and beyond, and would add an adjustment that would further increase it every 5 years starting in 2030 by the cumulative increase in the Medicare Economic Index (MEI) over the preceding 5 years. Additionally, the bill instructs the Secretary of Health and Human Services (HHS) to make annual budget neutrality corrections for both over- and underestimates in utilization starting with 2025.

  The legislation also requires the Secretary to update the direct costs (clinical staff wage rates, prices of medical supplies, and prices of equipment) used to calculate practice expense (PE) relative value units (RVUs) every 5 years. The Secretary is instructed to "consult with relevant stakeholders, including physician specialty societies" to make these updates.

  Finally, the bill would put limitations on year-to-year conversion factor variance. Starting in 2025, the conversion factor would not be permitted to vary by more than 2.5 percent (either positive or negative) from the previous year.

- H.R.___, **To amend title XVIII of the Social Security Act with respect to the work geographic index for physician payments under the Medicare program** – This bill would extend the floor for the Medicare work geographic index through 2025.

- H.R.___, **To amend title XVIII of the Social Security Act with respect to the work geographic index for physician payments under the Medicare program and to improve the accuracy of geographic adjustment factors under such program** – This bill would extend the floor for the work geographic index through 2025 and update the calculation of the work geographic index to require the most recent data on wages or costs.

- H.R. 3674, **the Providing Relief and Stability for Medicare Patients Act of 2023** – This bill would increase the nonfacility practice expense relative value units (RVUs) by ten percent in 2024 and 15 percent in 2025 for services with a nonfacility practice expense based on 65 percent or more of the direct practice expense attributed to equipment and supply costs. This would be done without a budget neutrality requirement. The bill is intended to avoid fee schedule changes with cuts to office-based specialty care.

Within one year, the Comptroller General would submit a report with an analysis of the number of providers furnishing services covered by this section in a nonfacility setting over the last 20 years, a description of access to these services, including an analysis comparing these services to those furnished at other sites of service, and recommendations for improving access and minimizing consolidation.

Laboratories

- H.R. 2377**, the Saving Access to Laboratory Services Act** – This bill would require the HHS Secretary to require the collection and reporting of clinical diagnostic laboratory test data from a statistically valid sample of applicable laboratories for widely available tests rather than requiring reporting from each laboratory. This would apply to tests with payment rates less than $1,000 and that are performed by more than 100 laboratories.

  The reporting requirements for private sector payment rates of clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests would be delayed by three years to begin in 2027, and the frequency of reporting would be changed from every three years to every four years.

  Additionally, the definition of applicable laboratories would no longer be based on receiving a majority of revenue from Medicare and instead would be based on a minimum threshold of Medicare payments.

  Finally, the phase-in of reductions from the private payor rate would be changed to zero percent for 2024, 2.5 percent for 2025, and five percent for 2026 and each subsequent year, and would prevent any payment increases greater than 2.5 percent for 2024 and 2025, 3.75 percent for 2026 and 2027, and five percent for each subsequent year.

- H.R.___**, To amend title XVIII of the Social Security Act to revise the phase-in of clinical laboratory test payment changes under the Medicare program** – This bill would push the phase-in of clinical laboratory test payment changes back by one year.

Quality Measurement and Payment

- H.R.___**, To amend title XVIII of the Social Security Act to extend incentive payments for participation in eligible alternative payment models** – This bill would extend the five percent incentive payments for participation in an Advanced Alternative Payment Model (A-APM) under

the Quality Payment Program to 2026 and establish a five-year cap for how long providers can receive the incentive payment.

- H.R. ___, **To amend title XVIII of the Social Security Act to exempt certain practitioners from MIPS payment adjustments under the Medicare program based on participation in certain payment arrangements under Medicare Advantage** – This bill would exempt physicians participating in a Medicare Advantage (MA) APM from Merit Based Incentive Payment System (MIPS) reporting requirements.

- H.R.___, **the Fewer Burdens for Better Care Act of 2023** – This bill would include public comments from stakeholders such as physician societies in the decision to remove National Quality Forum (NQF) quality measures.

- H.R. 5395, **the SURS Extension Act** – This bill would extend the Small Practice, Underserved, and Rural Support (SURS) program through 2029.

- H.R.___, **To amend title XVIII of the Social Security Act to allow for the use of alternative measures of performance under the Merit-based Incentive Payment System under the Medicare program –** This bill would allow CMS to use measures for MIPS payment for an entity other than a physician, such as for outpatient and inpatient hospitals, as long as the measure would not result in a lower score for a physician.

Health Information Technology (IT)

- H.R.___, **the Improving Seniors Timely Access to Care Act of 2023** – This bill would incorporate the Improving Seniors' Timely Access to Care Act, which unanimously passed the House in the 117th Congress (Impact summary), but did not pass the Senate because of its cost. This section includes the act mostly unchanged. The text notes that none of the amendments made are to be construed to affect the finalization of the Advancing Interoperability and Improving Prior Authorization proposed rule (Impact summary). Notably, this version does not include the $25 million that was authorized under the version that passed the House to carry out the act. These requirements apply to items and services covered by MA plans except for Part D drugs.

- H.R.___, **To amend title XVIII of the Social Security Act to promote provider choice using real time benefit information** – This bill would require prescription drug plan (PDP) sponsors to implement electronic real-time benefit tools within one year of enactment. PDP sponsors would also have to allow providers to choose any real-time benefit tool as long as it includes the required information and is not a security risk.

Drugs and Medical Supplies

- **H.R. 1352, the Increasing Access to Biosimilars Act of 2023** – This bill would establish a three-year voluntary shared savings demonstration project to increase access to biosimilar biological products under Medicare Part B. Under the demonstration, Medicare would provide an additional payment to providers for administering lower-cost biosimilar products equal to the different in payment between the biosimilar and the reference product.

- **H.R. 5526, the Seniors' Access to Critical Medications Act of 2023** – This bill would clarify the application of the in-office ancillary service exception to the physician self-referral prohibition for drugs and require CMS to remove the frequently asked questions on its website that prohibit or seek to prohibit such arrangements.

- **H.R. 4402, To amend title XI of the Social Security Act to clarify manufacturer transparency reporting requirements for certain transfers used for educational purposes** – This bill would include peer-reviewed journals, journal reprints, journal supplements, medical conference reports, and medical textbooks to manufacturer transparency reporting requirements for educational purposes.

- **H.R. 5555, the DMEPOS Relief Act of 2023** – This bill would adjust payment for Durable Medical Equipment, Prosthetics, Orthopedics and Supplies (DMEPOS) for items furnished during 2024 so that the transition rules pay fee schedule amount equal to 90 percent of the adjusted payment amount and ten percent of the unadjusted fee schedule amount. The covered items are those that were competed under the Round 2021 DMEPOS Competitive Bidding Program without executed contracts and which did not revert to the unadjusted fee schedule amount in 2021. The transition rule would also be applied to all applicable items and services in areas other than rural or noncontiguous areas beginning in 2025.

Rehabilitation

- **H.R. 1406, the Sustainable Cardiopulmonary Rehabilitation Services in the Home Act** – This bill would make permanent the in-home cardiopulmonary rehabilitation flexibilities established during the COVID-19 pandemic, expand the definition of originating sites, and remove geographic site restrictions. HHS would be required to develop rules that establish standards for designation of the home for individuals with status as a provider-based organization consistent with the Hospital Without Walls program for cardiac rehabilitation, pulmonary rehabilitation, and intensive cardiac rehabilitation. These programs would also be included under telehealth codes.

- H.R. 2583, **the Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023** – This bill would expand the site and types of providers who can deliver cardiac rehabilitation programs and pulmonary rehabilitation programs beginning January 1, 2204.

- H.R. 4878, **the Enabling More of the Physical and Occupational Workforce to Engage in Rehabilitation (EMPOWER) Act** – This bill would prevent CMS from imposing supervision requirements for outpatient physical therapy and outpatient occupational therapy that are different from applicable state law. The Government Accountability Office would also be required to conduct an analysis of how the Medicare Part B 15 percent payment differential for services provided by occupational therapy assistants and physical therapy assistants has impacted access to these services in rural and underserved areas.

Physician-Owned Hospitals

- H.R.___, **To amend title XVIII of the Social Security Act to revise certain physician self-referral exemptions relating to physician-owned hospitals** – This bill would exempt covered rural hospitals from physician self-referral requirements that are located more than a 35-mile drive (15 miles in mountainous terrain or with secondary roads only) from the nearest hospital. The limitation on expansion of facility capacity of physician-owned hospitals.

Telehealth

- H.R. 4104, **the Preserving Patient Access to Home Infusion Act** – This bill clarifies congressional intent to preserve patient access to home infusion therapy under Medicare and includes pharmacy services under covered services. Payment to a qualified home infusion therapy supplier for administration in the home would refer to payment for each day the drug was administered regardless of whether the supplier was physically present and requires that payment when a supplier is not present for administration be 50 percent of the amount that would have been paid if they were present. Nurse practitioners and physician assistants would also be allowed to establish and review a home infusion plan of care.

- H.R.___, **the Telehealth Privacy Act of 2023** – This bill would prohibit the Secretary from making a physician's address publicly available if their address is required on an enrollment or billing form for telehealth services at a distant site that is the residence of the physician.