July 10, 2024

Hon. Jason Smith
Chair, House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Hon. Richard Neal
Ranking Member, House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Hon. Vern Buchanan
Chair, House Ways and Means Committee
Health Subcommittee
1102 Longworth House Office Building
Washington, DC 20515

Hon. Lloyd Doggett
Ranking Member, House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith, Ranking Member Neal, Chairman Buchanan and Ranking Member Doggett;

The American College of Allergy, Asthma and Immunology (ACAAI) is pleased to provide this letter in support of the Ways and Means Committee's work to support independent medical practices. The Committee's May 23 hearing on this topic discussed solutions to many of the challenges facing medical practices.

ACAAI represents more than 6,000 board certified allergists and healthcare professionals. Allergists specialize in treating both adult and pediatric patients with chronic conditions such as asthma, food allergies, hives or urticaria, stinging insect hypersensitivity, sinus problems, allergic rhinitis, anaphylaxis, immune deficiencies, and atopic dermatitis or eczema, among other things.

This letter includes our recommendations for how Congress can support independent medical practices.

❖ Reduce Administrative Burden

One of the most important ways Congress can help the healthcare workforce is by reducing administrative burdens on physicians. The growing administrative burdens on practices due to policies from Congress, CMS and commercial health plans are a major contributor to physician burnout.

The U.S. Surgeon General's statement - Advisory on Addressing Healthcare Worker Burnout - acknowledges that administrative burdens contribute to burnout, "Several factors likely contributed to the immense challenges and demands that health workers faced even before the COVID-19 pandemic: a rapidly changing healthcare environment,

where advances in health information and biomedical technology are accompanied by burdensome administrative tasks, requirements, and a complex array of information to synthesize."

These administrative burdens are especially difficult for small practices, who do not have the resources to understand and manage these responsibilities as well as older clinicians who would rather leave the clinical workforce than deal with these challenges.

Administrative burdens also impose financial costs on practices. Research suggests administrative spending accounts for 15 - 30% of total healthcare spending which translates to upwards of $1 trillion.

- Change Healthcare and Cybersecurity

The Change Healthcare cyberattack from February caused major cashflow and administrative issues for medical practices. While the situation has greatly improved, functionality of the Change Healthcare clearinghouse is not fully restored. Medical practices must engage in many costly administrative workarounds to ensure claims are submitted and paid, and to access the remittance advice for each claim.

It is clear that Congress intends to respond to this cyberattack by pushing for more cybersecurity requirements in the healthcare system. ACAAI supports strong cybersecurity but is concerned that new cybersecurity requirements from Congress will be another unfunded mandate on practices. Congress must provide financial resources to help medical practices comply with any new cybersecurity requirements.

- Value-based Payments

Value-based payment programs such as MIPS and Alternative Payment Models (APM) are a major source of administrative burdens. The cost and quality goals of these programs are laudable but require a substantial resource investment to succeed with limited opportunities for significant payment increases. Congress must simplify these programs and recalibrate the payment incentives to ensure that they provide meaningful financial rewards.

- Prior Authorization

Prior authorization is among the top administrative pain points for medical practices. It is common knowledge that health plans are overutilizing prior authorization and making the process more difficult than it needs to be. Upwards of 90% of prior authorizations are approved either by the health plan or upon appeal. The low rate of appropriately denied prior authorization requests shows that prior authorization does not need to be used as widely as it is. The administrative burdens of prior authorization far outweigh

the potential benefit of preventing wasteful services. This ultimately creates barriers to patients accessing care.

Many practices devote multiple medical staff members to exclusively submit prior authorizations. Rather than use their training to care for patients, these staff must spend their time engaged in a manual, administrative process.

ACAAI endorsed the *Improving Seniors Timely Access to Care Act*, which would codify regulations that streamline the prior authorization process. We encourage Congress to pass this legislation's additional restrictions on how health plans can use prior authorization. This bill should penalize health plans for high rates of improperly denied requests and incentivize "gold card" programs that let providers with high approval rates avoid some of these requirements. We urge CMS to adopt necessary guidelines to ensure that payers do not circumvent this concept by preventing clinicians who prescribe higher-cost biologics from reaching the threshold needed to achieve the gold card status. CMS should conduct appropriate oversight over gold carding programs.

- No Surprises Act

The No Surprises Act, while incredibly beneficial for patients, creates significant administrative burdens on medical practices through its Good Faith Estimate (GFE) and Advanced EOB (AEOB) provisions.

The GFE, as currently enforced, requires a convening provider or facility to furnish an uninsured or self-pay patient with a "good faith estimate" of the cost for the care they reasonably expect to provide to the patient. Many practices already provide this information to patients upon request, but the GFE standardizes the format and timeliness of these notifications.

Additionally, practices will need to send their GFE to a patient's health plan so that the health plan can furnish the patient with an AEOB that lists both the GFE price and the insurance price side-by-side. CMS has delayed enforcement of the AEOB provision while it develops a data standard for all parties to electronically exchange the necessary information with each other. However, CMS is not paying adequate attention to the operational workflow burdens necessary to comply with this requirement.

We support price transparency that helps patients understand the cost of their care. However, we believe the NSA GFE and AEOB requirements must be reformed to reduce burdens placed on practices by better aligning the price transparency requirements with existing methods for providing patients with cost estimates.

❖ **Increase Medicare Reimbursement to Physicians**

Another factor contributing to physician burnout is declining reimbursement rates from both government and commercial payers. These reimbursement challenges - combined with the many administrative burdens - are key contributors to physician burnout and workforce challenges that the Committee hopes to address. Low Medicare payments have a compounding effect across commercial payers who typically negotiate their rates based on Medicare rates.

MedPAC acknowledges the full scope of this issue by showing how Medicare reimbursement has significantly lagged behind the Medicare Economic Index (MEI) since 2010. Clinicians can only earn meaningful positive Medicare reimbursement increases through programs like MIPS and APMs. However, it is increasingly difficult to earn a meaningful positive payment adjustment through MIPS, and APMs are not viable options for many specialists. Congress must pass legislation that provides regular and meaningful positive updates to the Medicare Physician Fee Schedule (PFS) Conversion Factor (CF) to account for both rising inflation and the fact that practices are not reimbursed for the financial costs of administrative burdens described above.

Each year, physicians spend the final weeks of the year advocating for Congress to prevent various Medicare reimbursement reductions from taking effect at the start of the forthcoming calendar year. Absent Congressional action, in 2025, physicians will receive a 7.68% payment reduction due to:

- 4% statutory PAYGO reductions from the American Rescue Plan Act (ARPA).
- 2% Medicare sequestration reductions.
- 1.68% budget neutrality increase to the 2024 Medicare Physician Fee Schedule (PFS) Conversion Factor (CF) expiring.

It is imperative that Congress prevents these cuts from taking effect and passes legislation to more sustainably reform Medicare reimbursements to physicians. We recommend that Congress:

1. Pass H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which permanently ties annual Medicare reimbursement updates to MEI.
2. Pass H.R. 6371, the Provider Reimbursement Stability Act of 2023, which reforms how CMS budget neutrality adjustments are calculated.
3. Permanently waive the 4% PAYGO reduction from ARPA.

4. Stop extending Medicare Sequestration payment reductions. Sequestration was supposed to expire in 2021. It has since become clear that Congress does not intend to let sequestration ever expire.

5. Restore funding for the MIPS Exceptional Performance bonus and the full Advanced APM Incentive Payment.

We understand that many of these policies require spending offsets. We believe that the necessary offsets can be found by enforcing fraudulent upcoding by Medicare Advantage (MA) plans. One study estimates that MA plans overcharge Medicare by between $83 billion and $127 billion. MedPAC estimates that Medicare pays MA plans $88 billion more than if they were covered under traditional Medicare.

We support the choice MA plans provide to beneficiaries. However, it is not right that MA plans are earning huge Medicare payments to which they are not entitled while medical practices continue to face annual Medicare payment reductions.

An additional $1.1 billion can be saved by reforming Pharmacy Benefit Managers (PBMs).

❖ **Pass the No Fees for EFTs Act**

Physician practices are facing huge financial challenges because of low reimbursement rates from commercial and government payers - combined with record levels of inflation. The last thing physician practices need is another payment cut. However, many health plans have found a way to force more unnecessary payment reductions on our practices through fees for EFT transactions. These fees, which typically range from 1% - 3%, are akin to an employer charging a fee to their employee for direct depositing their paycheck into their bank account instead of giving them a paper check.

HIPAA was established to create standardized electronic transaction sets for which no fees would be permitted. 45 CFR 162.925 allows health plans to charge a nominal transaction fee to cover banking costs. This fee is estimated at $0.34 per transaction. The regulation does not permit health plans to charge any fees beyond this. However, some health plans use third-party companies to facilitate the EFT transaction on their behalf - which have exploited what they view as a loophole in the EFT standard to charge healthcare providers a fee for EFT transactions.

Providing relief from EFT fees is essential because it is supposed to be the only no-fee electronic payment option for physician practices. Health plans are increasingly attempting to pay providers with virtual credit cards (VCC). These payment products are electronic numbers processed through a practice's credit card system that carry

similarly high and unnecessary fees. Health plans cannot require practices to accept VCCs. However, the VCC opt-out process is another administrative burden. What's more, opting out of VCCs provides no relief if the alternative (EFT payments) carries a similar fee.

The No Fees for EFT Act will help close the loophole that payment vendors exploit by prohibiting EFT fees in the operating rules for the EFT transaction standard.

CMS does not have any authority to regulate VCCs. Congress should pass legislation that prohibits all commercial health plans from paying providers using a VCC unless the provider consents to the payment in advance. This changes VCCs from an opt-out to an opt-in payment option. Physicians should also be allowed to opt out of VCC payments for all transactions instead of opting out of each transaction individually.

- **Simplifying Merit-Based Incentive Payments (MIPS) and Advanced Payment Models.**

Value-based payments, while well-intentioned, can be burdensome for allergists treating chronic conditions. As currently constructed, programs such as MIPS require significant investment of resources to effectively participate but have limited opportunities for physicians to receive significant payment increases as a reward for this investment. Allergists would benefit from less burdensome and more meaningful requirements to succeed in these programs, with a reformed payment incentive system to increase the benefits of succeeding in value-based payment programs. We appreciate comments from Health Subcommittee Chairman Vern Buchanan acknowledging financial and time burdens MIPS compliance imposes on practices.

Additionally, physicians would have more success in value-based payment models if they were specifically tailored to the conditions they treat. We are disappointed that CMS has not tested any of the physician-focused payment models (PFPM) recommended by the PFPM Technical Advisory Committee (PTAC).

In the MACRA legislation that created MIPS, Congress intended for PFPMs to serve as a physician-led alternative pathway to value-based care for chronic conditions to supplement MIPS and Advanced APMs. ACAAI's model, the Patient-Centered Asthma Care Payment Model, was among the dozens of models that the PTAC recommended to CMS. Our model is an example of an innovative reimbursement model to reward effective chronic care management for asthma. Congress should direct CMS to dedicate a portion of CMMI's budget to implement PFPM recommended by PTAC.

We appreciate the Committee's June 27 hearing on improving value-based care programs such as MIPS.

❖ **PBM Reform**

Physicians should be able to prescribe medications that, according to their expert opinion, would best improve the quality of life for someone living with a chronic condition. This is especially true for treating chronic conditions such as asthma where the popular and effective inhaler Flovent was recently removed from the market. Now, some PBMs are refusing to include the cheaper, generic version on their formularies. The influence PBMs have on drug availability should be put into question, especially for treating chronic conditions. ACAAI's Advocacy Council has endorsed all major bipartisan legislation to reform PBMs. We urge the Committee to continue its strong push to pass a law that would reign in the influence of PBMs and improve patient access to medications.

❖ **Conclusion**

Thank you for your consideration of our recommendations and for your leadership on issues that impact independent physician practices. Please do not hesitate to contact Matt Reiter (reiterm@capitolassociates.com) or Luke Schwartz (schwartzl@capitolassociates.com) if you wish to discuss our recommendations in more detail.

Sincerely,

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