June 13, 2024

The Honorable Ron Wyden
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Mike Crapo
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: EDPMA Feedback to White Paper, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B"

Chairman Wyden and Ranking Member Crapo:

The Emergency Department Practice Management Association (EDPMA) is the nation's only professional trade association focused on the delivery of high-quality, cost-effective care in the emergency department. EDPMA's membership includes emergency medicine physician groups of all sizes and billing, coding, and other professional support organizations that assist healthcare clinicians in our nation's emergency departments. Together, EDPMA members see or support approximately 60% of all annual emergency department visits in the country. For more info, please visit EDPMA.org.

Re-envisioning a plan for improving the quality of and access to physician services provided to Medicare beneficiaries can only occur after Congress first stabilizes the Medicare Physician Fee Schedule (MPFS) through two policies: (1) the creation of an annual inflationary update and (2) the modernization of budget neutrality requirements. Although there are additional substantive reforms that would benefit the MPFS, indexing the MPFS for inflation and modernizing the budget neutrality requirement are critically important, foundational steps that must be taken first. Each of these critical steps is described in turn below. However, we would first like to emphasize the unique impact that Medicare payment instability has on emergency medicine practices.

Although Medicare reimbursement issues affect all clinicians in the program, emergency medicine providers are in a unique situation compared to nearly every other medical specialty, due to the longstanding federal law EMTALA (Emergency Medical Treatment and Labor Act). Since 1987, EMTALA has provided a statutory guarantee that every patient who presents to an emergency department must be evaluated and medically stabilized regardless of the patient's insurance status or ability to pay for their care. Essentially, 100% of all emergency patients benefit from EMTALA's protections and 100% of emergency care is provided under EMTALA before the physician knows what payment – if any – will be rendered for clinical care. EMTALA is a critical feature of our nation's safety net and emergency care system. EDPMA members are proud to be a pivotal part of that safety net.

As a direct result of EMTALA, emergency physicians see patients with a broad representation of insurance statuses and products, including uninsured, Medicaid, Medicare, and commercially insured patients, each of which typically makes up about 25% of an emergency department's cases. It is well established that the ultimate reimbursement for uninsured, Medicaid, and Medicare services is less than the actual cost of providing clinical care to these patients. As a result, on average, EMTALA's requirements create a significant unfunded gap for approximately 75% of the patients seen in our nation's emergency departments. Coupled with significant workforce challenges in recent years, this results in a substantial strain on emergency care practices.

These dynamics also mean that emergency physician practices are highly sensitive to downward movements, fluctuations, and the absence of inflation adjustments for reimbursement rates of all payors, including Medicare. Emergency physician practices cannot adjust to reimbursement decreases in the same way that other specialties can. When reimbursement rates go down or are not adjusted for inflation, other specialties *not* subject to EMTALA have more flexibility to adjust processes for patient financial screening or patient scheduling to ensure the economic stability of their practices. For example, they can first inquire about patients' ability to pay, require insurance information or payments before care is delivered, or refuse to see patients at all in response to reductions or changes in reimbursement. Emergency physician practices have the unique opportunity, but also the affirmative challenge of providing clinical care *first*, and only afterwards attempting to collect appropriate reimbursement in order to sustain their practices and provide timely patient access to care. **This makes emergency care uniquely vulnerable to the downward trend in Medicare reimbursements. To avoid stretching the safety net beyond its breaking point, the emergency medicine community needs the MPFS to be on stable ground before enactment of additional substantive reforms.**

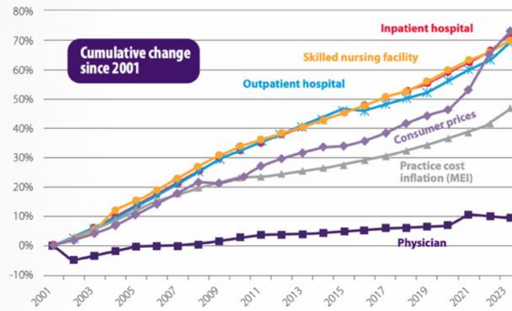
With that context in mind, we have provided answers to several of the questions posed in the Committee's RFI. We have limited our feedback to the RFI questions we are best suited to answer.

RFI question: As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?

Unlike Medicare's other major payment systems, the MPFS lacks a mechanism to reflect annual inflation, leaving physicians to absorb annual increases in the cost of practice on top of any additional reimbursement reductions. Not surprisingly, this has resulted in physician reimbursement falling significantly behind inflation metrics, behind the reimbursement of all other providers, and well behind the reimbursement of other sectors of health care, as this graph by the American Medical Association illustrates:

Medicare updates compared to inflation (2001–2023)

Adjusted for inflation in practice costs, Medicare physician pay declined 26% from 2001 to 2023.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

Updated April 2023

We are appreciative of the fact that the white paper referenced this fact. **It is imperative that Congress provide a mechanism for physician reimbursement to keep pace with the rising costs of providing medical care.** The Medicare Economic Index (MEI) is specifically designed to measure annual increases in the cost of practice. It provides the most relevant inflation metric for the MPFS. For 2024, the MEI is +4.6%. Failure to do so will inevitably result in serious beneficiary access challenges, as noted in the Medicare Trustees' 2023 Report to Congress, which warned that access to Medicare physicians would become "a significant issue in the long term," absent a change in the delivery system or in the level of update. **The bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474) would provide an annual inflationary update to the MPFS based on the MEI. This is a basic, foundational policy that will provide stability to the Medicare program. We urge the Senate Finance Committee to include a similar policy in any future physician payment reform legislation.**

RFI question: What policies, if any, would help to address inaccurate utilization assumptions that trigger budget-neutrality adjustments, or else to account for said assumptions in subsequent rate-setting processes? Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?

As the white paper alludes to, over the years, certain policy decisions by the Centers for Medicare and Medicaid Services (CMS) have added to reimbursement instability by triggering the statutory requirement for budget neutrality. Most recently, CMS' creation and implementation of a new add-on code (G2211) highlighted the "winners versus losers" dynamic created by this policy: by triggering a Fee Schedule-wide budget neutrality adjustment, implementation of this code alone was responsible for a -2% reduction in Medicare payments for emergency physicians in 2024 relative to 2023.

As an initial matter, Congress must update the threshold at which budget neutrality is triggered. That threshold is set in statute at $20 million, a number that has never been updated since its enactment in the early 1990s. Unless this threshold is updated and then indexed from the updated level, budget neutrality will be triggered more and more frequently as time goes by. That not only creates instability for Medicare clinicians, but it will also make it more difficult for CMS to implement policies to keep pace with innovation, as even minor policy changes will eventually trigger the need for budget neutrality reductions. To avoid across-the-board reductions in the future, we urge Congress to modernize the threshold at which budget neutrality is triggered. **Updating the threshold to at least $53 million would reflect the three decades of inflation since the threshold was first created. Additionally, indexing the new level on a**

regular basis is a crucial long-term reform that will avoid recreation of the same problem in the future. Section 5 of the bipartisan Physician Fee Schedule Update and Improvements Act (H.R.6545) accomplishes both of these goals, and we urge the Finance Committee to explore similar language in any Senate package.

To prevent unduly large fluctuations, the Congress could also explore capping budget neutrality reductions at a certain percentage in any given year. However, we urge caution in the creation of any "recoupment" or "true-up" mechanism. The physician community does not have any input into the process by which CMS sets its utilization assumptions, so should not experience claw-backs if CMS underestimated utilization. Such a mechanism would only create more automatic payment reductions divorced from care quality that Congress would be called upon to mitigate or avert in future years.

RFI questions: Current law updates reflect a differential between A-APMs and non-participants. How, if at all, should a new CF framework reflect participation in A-APMs as an incentive for participation? In considering a new design for future A-APM bonus payments, are there existing demonstrations that structure A-APM incentive payments to reward providers that attribute beneficiaries to the A-APM?

So long as the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) remains the foundational structure of updates to Medicare physician payments, the framework should provide an incentive for physicians to move to alternative payment models where they are available. However, to date, there have been virtually no options for emergency medicine providers to shift to APMs. While we believe that renewed investment must be made in the development of APMs (including further consideration of ACEP's Acute Unscheduled Care Model (AUCM) , which was highly recommended for adoption to the Secretary of HHS by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) in September of 2018), the appropriate incentives must be in place to support practices as they shift to those models. The current statutory language hinders movement into APMs due to an expiring APM incentive payment and rising eligibility thresholds. In fact, incentive payments provided under the Merit-Based Incentive Payment System (MIPS) might soon outweigh incentives to move into APMs, which could reverse any progress made to date on MACRA's goal of speeding transition to APMs and interfere with CMS' goal of moving all Medicare beneficiaries into value-based models by 2030.

RFI questions: What methodology should form the basis for incentive bonuses, if not total PFS revenue for all providers participating within an A-APM? What bonus structure best encourages new providers participating in A-APMs? Should the bonus continue to require participation thresholds, or modify or eliminate thresholds for greater participation?

The failure of MACRA to shift care into APMs for emergency medicine is primarily a function of the lack of available models. Until there are more clinically appropriate models available for participation of emergency physicians and other specialists, a redesign of the incentive structure is premature. Instead, Congress should focus on creating more APM participation options and support transition to those models by continuing a percentage-based APM incentive bonus as originally designed in MACRA. In addition, Congress should reduce the participation thresholds for physicians to qualify for the APM incentive. Practices have experienced serious difficulty in moving large percentages of the care that they deliver into models, which makes moving any care into a model meaningless for purposes of qualifying for the APM participation bonus.

RFI questions: How could Congress ensure a broader array of A-APM options, including models with clinical relevance to specialties or subspecialties confronting few, if any, such options? How could Congress encourage ACOs led by independent physician groups and/or with a larger proportion of primary care providers?

Congress must reinvest in PTAC and create meaningful requirements for the Secretary to implement at least some of the models recommended by the PTAC. To date, the Secretary has enacted *none* of the models recommended by the PTAC. As an example, EDPMA believes there is significant potential in the AUCM developed by ACEP and recommended by the PTAC, as mentioned above. These are precisely the types of efforts MACRA was designed to support, but because the Secretary is not required to implement any of the PTAC-recommended models, these efforts yielded no new or viable participation options for physicians.

In closing, we thank the Committee for its continued bipartisan focus on Medicare physician payment and we hope these initial responses are helpful to the Committee as it explores reform options. If you have any questions or would like additional information, please reach out to Cathey Wise, EDPMA's Executive Director, at cathey.wise@edpma.org.