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October 31, 2022

SUBMITTED ELECTRONICALLY VIA macra.rfi@mail.house.gov

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider, and Miller-Meeks:

The American Urologic Association (AUA) appreciates the opportunity to provide feedback on this request for information (RFI) to inform future legislative efforts to stabilize the Medicare payment system and reform the Medicare Access and CHIP Reauthorization Act (MACRA). We urge Congress to develop comprehensive reforms to the payment system that will remove the uncertainty Medicare beneficiaries and their providers face each year.

The AUA is a globally engaged organization with more than 22,000 members practicing in more than 100 countries. Our members represent the world's largest collection of expertise and insight into the treatment of urologic disease. Of the total AUA membership, more than 18,000 are based in the United States and provide invaluable support to the urologic

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community by fostering the highest standards of urologic care through education, research, and formulation of health policy.

Congress Must Stabilize and Provide for Growth in Physician Payment

The MACRA legislation repealed the sustainable growth rate (SGR) formula, revised the Centers for Medicare & Medicaid Services' (CMS) quality programs to reward physicians for high value care rather than volume of services provided, attempted to create a more streamlined quality program for physicians under the Merit Based Incentive Payment System (MIPS), and authorized bonus payments for physician participation in certain alternative payment models.

As the SGR cuts rose as high as 20 percent, Congress found itself in an annual cycle of passing legislation to eliminate these cuts while Medicare beneficiaries and providers were uncertain about the sustainability of the program. MACRA was developed to eliminate the SGR's volume-based targets, which were exceeded almost every year they were in effect, thus requiring reductions in the Medicare Physician Fee Schedule conversion factor, and to stabilize physician payment. The legislation provided modest and time limited conversion factor updates, which are no longer in effect, and would not have offset the budget neutrality reductions that have been required in 2020, 2021, and 2022.

Congress now finds itself back where it was in 2015: faced with passing an annual physician payment fix because of the limitations of the budget neutral system or allowing significant cuts to the conversion factor to be implemented. Medicare physician payment has stagnated for the last two decades because of the SGR experience coupled with MACRA's limited updates and retention of budget neutrality. Physicians have struggled to keep pace as practice costs, the consumer price index, and other factors have kept physician payments flat. Meanwhile hospital inpatient and outpatient reimbursement have increased because those systems include inflationary adjustments. The threat of yearly payment cuts to physician payments creates uncertainty and anxiety for physicians, who already feel overwhelmed and undervalued as they juggle patient care, prior authorization requirements, differing quality reporting requirements across payers, and increasing staffing costs. The AUA recognizes your goal not to dramatically increase spending. However, Medicare physician payment cannot be stabilized without eliminating the budget neutrality requirement and implementing an inflationary adjustment like those included in the other Medicare payment systems.



The AUA believes that to create an updated and equitable payment system the underlying inputs must also be sound and current. In the MPFS proposed rule for 2023, CMS outlined plans to rebase and revise the Medicare Economic Index (MEI), which measures practice cost inflation and serves as a mechanism to determine the portion of payments attributed to physician earnings and practice costs. The current MEI weights used in calculation of physician payments utilize data obtained from the American Medical Association's (AMA) Physician Practice Information (PPI) Survey, which was conducted in 2006. That means that the physician payments for year 2023 are based in part, on data that is 16 years old.

The agency proposed to update the MEI weights using 2017 data from the United States Census Bureau's Service Annual Survey but will not implement this change in CY 2023 because of the significant redistributive effect of the policy. We implore Congress to work with CMS to update the MEI and develop a mechanism to keep it current.

Finally, the system cannot be fixed without updates to the practice expense inputs, specifically the indirect practice expense of operating a medical practice, that are also used in the calculation of physician payments for Medicare services. CMS is currently using indirect practice expense data that is also 16 years old. In a revised system these inputs need to be updated regularly. Regularly updated data is a key component of a stable Medicare payment system with increases that are proportionate to economic changes.

Regulatory, Statutory, and Implementation Barriers That Need to be Addressed for MACRA to Fulfill its Purpose of Increasing Value in the U.S. Health Care System

Outside of the budget neutrality requirement, the compliance requirements of the Quality Payment Program (QPP) are incredibly complex despite Congress' stated intention to simplify CMS' quality reporting requirements in MACRA. The QPP includes two tracks—MIPS and advanced Alternative Payment Models (APMs); however, MIPS is not significantly more streamlined than the programs it replaced. Congress must strive to revise the QPP such that its requirements support the delivery of value-based care and improved quality and do not create new check the box exercises or administrative burden. On that account, the QPP has failed as some practices devote staff just to meet the program's reporting requirements.

Additionally, MACRA's statutory requirements have impeded Congress' goals for the program. For instance, MACRA dictated the weights of the different MIPS categories—quality, cost, promoting interoperability, and improvement activities. While the cost



category now comprises 30 percent of the physician's MIPS score, many do not feel that CMS' cost measures accurately reflect a physician's performance. In some ways, the statute got ahead of CMS' measurement tools, potentially penalizing participating physicians.

Increasing Provider Participation in Value-Based Payment Models

Value-based care models were created to provide better care for individuals, improve population health management strategies, and reduce health care costs. However, the programs created under CMS have fallen short on all three goals, and instead, created challenges for physicians and physician practices.

There is increased administrative burden and financial risk involved with participation in value-based models. There is significant investment in training staff at a time when there are staffing shortages and high turnover rates. This training often takes away time and resources that should be devoted to patient care. In addition, with so many variations in practices, including practice size, specialty type, practice location, and population demographics, a one-size fits all model simply does not work. Flexibility is key to provider participation as a model that is not adaptable will not take hold.

Recommendations to Improve MIPS and APM Programs

To improve the MIPS program, CMS must have the authority and resources to create programs that are meaningful to all providers and patients regardless of specialty type, while lowering the burden to participate in these programs. While we understand the constraints under the current payment system, we believe that collaboration with stakeholders will assist in creating more meaningful programs.

In addition, we appreciate that the agency currently provides pathways for quality measure and registry development, however measure development is costly and resource intensive. The AUA suggests that CMS or other agencies be authorized to underwrite measure development, particularly for medical specialty societies so that societies have the resources to develop meaningful measures. The AUA recommends that physician feedback on their performance under MIPS be provided to physicians in a timely manner, is actionable and relatable to their practice patterns and care. There is concern that when physicians receive feedback on their performance that this information is not helping to improve clinical outcomes or reducing health care costs. Finally, the AUA recommends that any quality payment incentives are large enough to cover the costs of the time and resources that are devoted to participating in a quality program.



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We would also recommend simplifying the reporting requirements and reporting tools used in quality programs, while aligning rules and administrative tasks across programs. In addition, educational resources for providers interested in participating in or are currently participating in MIPS and APMS could prove useful.

The AUA is always interested in working with Congress and CMS in creating high value, cost effective, efficient healthcare quality programs, as such we welcome the opportunity to meet with you to discuss these issues as you develop a legislative solution. Please contact Raymond Wezik, AUA Director of Policy and Advocacy, at rwezik@auanet.org with any questions or for further information.

Sincerely,

A handwritten signature in cursive script that reads "Eugene Rhee, MD, MBA".

Eugene Rhee, MD, MBA
Chair, Public Policy Council