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October 31, 2022

The Honorable Ami Bera, M.D.
172 Cannon House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier, M.D.
1123 Longworth House Office Building
Washington, D.C. 20515

The Honorable Earl Blumenauer
1111 Longworth House Office Building
Washington, D.C. 20515

The Honorable Bradley Scott Schneider
300 Cannon House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon, M.D.
2313 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael C. Burgess, M.D.
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad R. Wenstrup, D.P.M.
2419 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Mariannette Miller-Meeks, M.D.
1716 Longworth House Office Building
Washington, D.C. 20515

Submitted electronically to macra.rfi@mail.house.gov

RE: Request for Information on the Medicare Access and CHIP
Reauthorization Act (MACRA) of 2015

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

Established in 1943, the American Academy of Allergy, Asthma & Immunology (AAAAI) is a professional organization with more than 6,700 members in the United States, Canada and 72 other countries. This membership includes allergist/immunologists (A/I), other medical specialists, allied health and related healthcare professionals—all with a special interest in the research and treatment of patients with allergic and immunologic diseases.

In the paragraphs that follow, we provide our perspectives on the challenges our members face under the Medicare physician fee schedule and the Quality Payment Program under the Medicare Access and CHIP Reauthorization Act (MACRA), along with recommended improvements.

Challenges under the Medicare Physician Fee Schedule

AAAAI is deeply concerned about the ongoing reductions in payments to physicians under the Medicare Physician Fee Schedule (PFS), which have created an increasingly unsustainable environment for A/I physician practices. While Congress sought to improve the flawed physician payment mechanism by passing legislation that repealed the Sustainable Growth Rate (SGR) formula and established a value-driven payment system that rewards quality improvement, the new law failed to continue linking physician payment updates to an inflation proxy to ensure payments kept pace with rising costs. And, while we are in a period of incredibly high inflation, our

members' practices are struggling to hire and retain staff, as well as make needed investments in equipment and purchase routine supplies. We note that every other Medicare payment system includes a mechanism to account for inflation, and most every other Medicare provider is anticipating or already receiving, an increase in their 2023 payments. As noted below, Medicare physicians face a 4.42% reduction in CY 2023, while hospitals, surgery centers and most other providers will see sizable payment increases. To mitigate this disparity, we urge Congress to modify the Medicare physician payment formula by adding an inflationary adjustor, such as the Medicare Economic Index (MEI).

Another significant challenge is the impact of mandatory adjustments to maintain budget neutrality within the PFS. Under the budget-neutral system, PFS changes cannot increase or decrease expenditures by more than \$20 million in a year, and when they do, adjustments are applied to the PFS Conversion Factor. As you know, CMS implemented revised values for office and outpatient (O/O) evaluation and management (E/M) services that resulted in a 10.2% reduction in CY 2021, and another 3.8% reduction in CY 2022. Congress intervened to temporarily mitigate these cuts, leaving physicians to contend with lesser reductions of 3.3% and 0.80%, respectively. In CY 2023, CMS is proposing additional revisions to inpatient E/M services, which – coupled with the previous O/O E/M changes – result in a 4.42% reduction. Hopefully, Congress will again intervene to prevent these cuts while it seeks a long-term solution to the PFS challenges.

Also frustrating is that the Centers for Medicare and Medicaid Services (CMS) continues to implement or propose other policies that have already, or would in the future, prompt even more negative adjustments to maintain budget neutrality (e.g., new preventative services, expanded access to existing services, etc.). The magnitude of such adjustments are unsustainable and prompting many physicians to consider selling their practices, retiring early, or leaving the practice of medicine for other opportunities. ***We urge Congress to allow the Secretary to use discretion in modifying, adjusting or waiving budget neutrality requirements, particularly where there is a change in law or regulation.***

Finally, we are concerned with delays in updating key data sets that are used to make practice expense payments (e.g., clinical labor, supplies and equipment, and malpractice premiums). For example, in CY 2022, CMS updated clinical labor prices to reflect increased wages for these personnel (e.g., nurses, technical professionals, etc.), an exercise that had not occurred in the previous two decades. Not surprisingly, wages for clinical staff increased tremendously over the 20 year period. As expected, and coupled with required budget neutrality adjustments, some A/I services saw reductions of up to 17%. We find it ironic that CMS recognized that our expenses had increased for labor, yet many of our services were drastically reduced. In addition to the recommendations for addressing budget neutrality, ***we urge Congress to require the agency to make regular and consistent updates to practice expense data sets. We further urge Congress to authorize the Secretary to exempt practice expense changes from budget-neutrality adjustments, given the rising cost of labor, supplies, equipment and malpractice insurance are outside the control of physicians.***

Challenges with the Quality Payment Program

There are Allergist/Immunologists in a wide variety of practice settings across the US, and *meaningful* participation in the Quality Payment Program system has not been available to the vast majority of them. Allergists/Immunologists who are in large healthcare systems and academic centers generally are not personally engaged in or even aware of the quality payment program because their electronic medical record systems are collecting measures data in the background, and will report measures for the specialties that generate the highest bonuses. Allergists/Immunologists in multispecialty groups tend to be fewer in number than their peers in other specialties, so those systems generally prioritize other areas of care on which to

focus quality reporting as well. Our small and solo practice physicians generally do not have the technological resources to engage in a meaningful way.

To address the needs of our members and support the move toward Value Based Care, the AAAAI developed a Quality Clinical Data Registry to facilitate participation in the Quality Payment Program on quality measures that reflect meaningful specialty care in Allergy/Immunology. This was necessary because many of the standard MIPS program measures have required data available to larger systems, but inaccessible to small and solo practices, such as pharmacy refill data, ER visits, etc. Unfortunately, many of the electronic medical records systems used by small and solo practices charge exorbitant fees over already high subscription costs to modify their systems to facilitate practice reporting of data to the AAAAI QCDR, or simply tell their customers that they are not able to link their system to it.

So whether in a large system and due to barriers to registry connectivity by their system's EMR, or simply on account of the extraordinary human resource burden required to participate for small to medium sized practices, many Allergists/Immunologists in all settings have had significant barriers to meaningful participation in the QPP. Further, CMS requirements for MIPS reporting change every year, making both the provision of the QCDR for the AAAAI and our members' participation in it consistently and extremely complicated, and very expensive. These factors combine to make what is supposed to be a program to enhance and improve the quality of patient care, and turn it into one that can do more harm than good for patient care by driving up healthcare costs. The AAAAI has, thus far, continued to offer a QCDR as a member benefit, while many other specialty societies chose to abandon the program during the pandemic. It is unknown at this time how much longer the AAAAI can continue to do so as CMS program requirements, EMR company barriers, and physician practice restraints present staggering challenges to continuing.

Like so many other small businesses, our solo and small practices especially struggled to survive during the pandemic. Most of these practices were able to take MIPS reporting exemptions offered during the pandemic. However, because many of them are still getting back up to speed, are unable to find sufficient clinical support staff, and in many cases have very large pediatric populations with very low Medicaid payment rates, they are unlikely to be able to participate in MIPS reporting once the pandemic exemptions are no longer available. Even those practices with relatively fewer Medicare patients in their patient population stand to face significant financial strain from marginally lower penalties imposed for non-compliance with the QPP program. The Allergy/Immunology specialty has long documented and worked to address healthcare disparities in the inner-city, in rural communities, and other lower income areas. Many of our practices serve a substantial number of Medicaid patients, and the hazardously low reimbursement for their care makes any financial penalty on Medicare reimbursement especially damaging to the practices' ability to continue serving anyone, and especially children from low income communities with severe allergies and asthma, where greatly increased incidence of severe disease is well documented.

Alternative Payment Models are not doing any better at including small and solo practices than the MIPS program. Indeed, we have heard in a number of areas that, due to APMs, small and solo practices have been eliminated from referral networks, and indeed from APM reporting entities themselves. Allergies and asthma as chronic conditions are not well suited to the risk adjustment models APMs are built upon. While there has been interest in an APM focused on asthma care, the AAAAI is not aware of implementation plans that have identified ways to account for risk adjustment or appropriate attribution to facilitate meaningful participation for Allergists/Immunologists. Therefore the additional incentive payments available to participants in APMs further exacerbates a healthcare system that already makes small and solo practice sustainability increasingly difficult.

We appreciate the opportunity to provide our perspectives on the aforementioned RFI. Should you have any questions, please contact Sheila Heitzig, Director of Practice and Policy, at sheitzig@AAAAI.org or (414) 272-6071.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Khan". The signature is fluid and cursive, with a large initial "D" and a long, sweeping underline.

David A. Khan, MD FAAAAI
President, American Academy of Allergy, Asthma & Immunology