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U.S. Toll Free: 1-866-RING-AUA (1-866-746-4282)
Phone: 410-689-3700
Fax: 410-689-3800
Email: AUA@AUAnet.org
Websites: AUAnet.org
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June 14, 2024

The Honorable Ron Wyden, Chair
Senate Finance Committee
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Michael Crapo, Ranking Member
Senate Finance Committee
U.S. Senate
239 Dirksen Senate Office Building
Washington, DC 20510

RE: Senate Committee on Finance, "Bolstering Chronic Care through Medicare Physician Payment: Current Challenges and Policy Options in Medicare B"

Dear Chair Wyden and Ranking Member Crapo:

The American Urological Association (AUA) applauds the Senate Finance Committee for releasing the recent white paper titled, "Bolstering Chronic Care through Medicare Physician Payment: Current Challenges and Policy Options in Medicare B". The Medicare program, its sustainability, and its payment policies are of great importance to our members and the Medicare beneficiaries they treat. The AUA was also pleased that the Committee held a related hearing on April 11th of this year and appreciates the Committee's renewed attention to this important topic. We write to offer comments in response to some of the questions under consideration raised in the Committee's white paper.

The AUA is a globally engaged organization with more than 22,000 physicians, physician assistants, and advanced practice nursing 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 15,000 are based in the United States and provide invaluable support to the urologic community by fostering the highest standards of urologic care through education, research, and the formulation of health policy.

Urologists play a crucial role in the care of patients with both chronic and acute urologic conditions, providing vital services that improve quality of life and often prevent serious complications. Despite the critical nature of urologists' work in enhancing patients' well-being, the existing Medicare reimbursement structure often fails to adequately compensate urologists for the advanced and specialized care they deliver. This discrepancy not only undermines the financial viability of urology practices but also jeopardizes patient access to high-quality care and innovative treatments.

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Physician payments have stagnated for the last two decades and physician practices must continue to pay market rate for supplies, equipment, and staff wages. For the last several years, Congress has intervened to prevent or mitigate cuts to the Medicare Physician Fee Schedule (MPFS), and the AUA is grateful for these actions. However, our members and the patients they treat deserve better than the unstable and uncertain reimbursement and access environment created by the annual threat of cuts.

Addressing Payment Update Adequacy and Sustainability

The statutory constraints placed on the Centers for Medicare & Medicaid Services' (CMS) MPFS, including the lack of updates and the budget neutrality requirement, limit the agency's ability to stabilize the MPFS and ensure appropriate access to the full range of specialty care without Congressional intervention. The AUA makes the following recommendations under this topic area.

Implement Inflationary Updates – According to an American Medical Association (AMA) analysis of Medicare Trustees data, Medicare physician payment has declined by approximately 30 percent when adjusted for inflation from 2001-2024. The MPFS does not receive necessary increases or adjustments for inflation, in contrast to other Medicare fee schedules, with the last statutory update of 0.5% implemented in 2019. The decline in reimbursement over the last two decades undermines physicians' ability to deliver essential medical services, jeopardizing patient access to timely and high-quality care. **Therefore, AUA recommends Congress provide a statutory update to the MPFS based on the Medicare Economic Index (MEI) to reflect the inflation in practice costs, including but not limited to clinical staff, rent, medical supplies and equipment, and insurance.** Legislation containing provisions to this end has been introduced in the House with the Strengthening Medicare for Patients and Providers Act (H.R. 2474). It is important to note that greater financial stability will lead to improved physician retention ensuring patients have access to timely and high-quality care, and allow investments in infrastructure, which can contribute to improved efficiency and quality of care delivery.

Address Budget Neutrality – Current Medicare statute requires changes to the MPFS be implemented in a budget neutral manner, which means that policies that increase or decrease Medicare spending by more than $20 million require that upward or downward adjustments be made by that excess amount to all physician services. Budget neutrality places unreasonable constraints on MPFS payments and potential policies. **Therefore, AUA recommends that Congress consider raising the budget neutrality threshold from $20 million to $53 million to accommodate changes in Medicare spending since this threshold has not been increased since 1992. Congress should also provide for an increase equal to the cumulative increase in the MEI every five years to allow this threshold to keep pace with inflation.** This will allow for more flexibility in adjusting physician payments and mitigate the dynamic where specialties feel they are pitted against each other when new codes are added to the MPFS or values for existing codes are proposed to be increased. Without positive updates to the MPFS conversion

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factor, the budget neutrality requirements exert even greater downward pressure on Medicare reimbursement and cause redistributive impacts to services under the MPFS. Legislation has been introduced in the House, the Provider Reimbursement Stability Act of 2023 (H.R. 6371), that would address this by allowing CMS to more accurately calculate the conversion factor by allowing corrections for over- or underestimates in utilization of services added to the MPFS. **AUA urges you to support this policy to address estimated utilization in the fee schedule.**

With respect to differential conversion factor updates for clinicians who participate in advanced alternative payment models (APMs) versus those who do not, the AUA believes that is a premature consideration and calls on CMS and Congress to first focus on expanding APM pathways and ensuring a level playing field that enables broader participation in APMs across specialties, clinical settings, and geographic areas.

Incentivizing Participation in APMs and Rethinking MIPS

AUA was pleased to learn that the Committee is interested in improving the Merit-based Incentive Payment System (MIPS) and identifying strategies to bolster more widespread adoption of APMs. The Medicare Access to CHIP Reauthorization Act authorized the CMS Quality Payment Program (QPP) to encourage physicians', including specialists like urologists, engagement in innovative healthcare delivery models, fostering a system that rewards improvements in the quality of care delivered. AUA believes that APMs, if implemented well, can incentivize improved quality and better care coordination, which can be especially valuable for conditions like prostate and bladder cancer that may require surgery, radiation, and medical oncology to treat. Unfortunately, in practice, these programs have not been broadly taken up and have fallen short of their promise and potential to streamline and positively transform the delivery of health care to Medicare beneficiaries.

The lagging adoption is partially attributable to the significant administrative burden and financial risk involved with participation in APMs and MIPS; practices in rural and underserved areas that are already facing bandwidth and resource limitations are particularly ill-equipped to take on this risk. A 2021 Government Accountability Office (GAO) analysis found that from 2017 through 2019, a smaller percentage of providers eligible to participate in advanced APMs in rural or health professional shortage areas participated in them compared to providers outside of these areas. Specifically, the GAO cites "a lack of capital to finance the upfront costs of transitioning to an APM, including purchasing electronic health record technology; and challenges acquiring or conducting data analysis necessary for participation" as barriers to adoption for providers in these areas. Just as troubling, evidence suggests a poor return on investment and misalignment in incentives for APM-participating providers in certain settings, with only 17 percent of independent physician practices participating in APMs receiving an APM Incentive Payment in 2023.

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Additionally, a 2021 study published in JAMA Health Forum found that it costs an estimated $12,811 and takes more than 200 hours per physician to comply with MIPS. And even with that investment of resources, there are serious questions about whether these investments result in any meaningful upside for practices—especially for smaller, independent practices where the administrative burden and up-front financing are particularly challenging—and whether the program actually results in higher quality care.

Current requirements for participation in APMs and MIPS are too burdensome, and the one-size-fits-all model does not work across practice areas, as well as clinical and geographic settings. Specialty physicians, like urologists, will find few physician-focused APMs and MIPS pathways available for them to meaningfully participate in the QPP program. While we understand the constraints under the current payment system, we believe that collaboration with stakeholders will assist in creating more meaningful programs and reducing burden for providers. **To improve these programs, 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.**

Furthermore, the AUA believes that quality payment incentives should be large enough to cover the costs of the time and resources that are devoted to participating in a quality program while also rewarding physicians for their participation. This is important because it ensures that healthcare providers are adequately compensated for the efforts they put into improving patient care. Not only can financial incentives be used to improve patient care, but this can also be used to provide incentives to urologists and other physicians to practice in underserved areas. **Therefore, Congress must ensure that quality payment incentives are commensurate with the investment of time and resources necessary for sustaining effective quality improvement efforts and ultimately enhancing the quality of care delivered to patients.**

The AUA appreciates your leadership and welcomes the opportunity to work with you to improve Medicare beneficiary access to care and ensure the care delivered by urologists and other physicians is reimbursed equitably. For any questions, please contact the AUA's payment & reimbursement team at paymentpolicy@auanet.org.

Sincerely,

Mark Edney, MD, MBA
Chair, Public Policy Council