Statement for the Record
Senate Finance Committee Hearing
Bolstering Chronic Care through Medicare Physician Payment
Submitted by the Society of Gynecologic Oncology
April 25, 2024

The Society of Gynecologic Oncology (SGO) applauds the Senate Finance Committee for holding the recent hearing, *Bolstering Chronic Care through Medicare Physician Payment*. This is an important step in protecting Medicare beneficiaries' access to high-quality care.

The SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. Our more than 2,800 members include physicians, advanced practice providers, nurses and patient advocates who collaborate with the Foundation for Women's Cancer to increase public awareness of gynecologic cancers and improve the care of those diagnosed with gynecologic cancers. Our primary mission focuses on supporting research, disseminating knowledge, raising the standards of practice in the prevention and treatment of gynecologic malignancies, and collaborating with other organizations dedicated to gynecologic cancers and related fields, all with the ultimate vision of eradicating gynecologic cancers.

Gynecologic oncologists play a multifaceted role in providing care for women with gynecologic cancer. Gynecologic oncologists are involved in the diagnosis of gynecologic cancer, developing personalized treatment plans for patients, performing complex surgeries, overseeing the administration of chemotherapy, and monitoring patients to detect recurrence or complications. Unfortunately, Medicare reimbursement has not kept pace with the costs of delivering this complex care.

The entire physician community continues to face unpredictable Medicare reimbursement rates and rising inflation – a perfect storm of financial instability that threatens SGO members' ability to care for patients. Therefore, SGO recommends that Congress work with physicians to implement long-term, systemic reforms that bring stability to the Medicare physician payment system ending this cycle of annual payment reductions and preserving beneficiary access to medical services. Specifically, we urge you to consider supporting the following legislative solutions:

- Annual Inflationary Adjustments: The Medicare Physician Fee Schedule (MPFS) does not receive necessary increases or adjustments for inflation, in contrast to other Medicare fee schedules. Not only does the MPFS not receive annual inflationary increases, the last statutory increase to the MPFS conversion factor of

0.5% was applied in 2019. SGO supports an annual inflationary adjustment, equal to the Medicare Economic Index (MEI) or some other inflationary factor. An annual inflation-based update to the MPFS will help practices cover the growing cost of clinical staff, rent, medical supplies and equipment, malpractice insurance, and other necessary expenses. Moreover, it will help to protect the supply of our nation's physicians and preserve patient access to care, particularly in areas where there may be a shortage of specialized providers, like gynecologic oncologists.

- 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. This threshold has not changed since 1992. SGO recommends that Congress consider raising the budget neutrality threshold from $20 million to $53 million to accommodate changes in Medicare spending, allowing for more flexibility in adjusting physician payments. Congress should also provide for an increase every 5 years equal to the cumulative increase in MEI to ensure that physician payments keep pace with inflation and the cost of delivering care.
- Updates to Practice Expense: Medicare bases its payment rates under the MPFS in part on estimates of the resources used in furnishing each service to a typical Medicare patient. For each service, there is a valuation for practice expense (PE), which is composed of the direct and indirect practice resources involved in furnishing medical services. SGO recommends that the Secretary of Health and Human Services, no less than every 5 years, update prices and rates for direct cost inputs for PE relative value units which includes clinical wage rates, prices of medical supplies, and prices of equipment. PE data should be updated on a regular basis to account for the inevitable changes in technology, practice patterns, clinical labor rates, and other factors that influence these inputs. Updating the data more regularly will provide greater stability within the payment system.

Moreover, SGO appreciates the Committee's interest in making improvements to the Centers for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP), including simplifying the Merit-based Incentive Payment System (MIPS) and identifying strategies to bolster widespread adoption of alternative payment models (APMs).
The purpose of value-based care programs is to drive down health care costs and improve patient outcomes, but those goals cannot be achieved without robust physician participation in these models. Unfortunately, there are challenges for physicians, such as financial risk and administrative burden. In an environment of stagnant Medicare reimbursement, physicians are even more averse to the financial risk posed by these

programs. Additionally, physician practices vary by size, specialty, and location; therefore, it is important that APMs are developed in a way that is feasible and makes sense for different practices and patient populations. There are significant financial investments required to develop and implement an APM putting this option out of reach for many specialties or health systems. Congress should ensure that CMS is provided with the necessary resources to support measure and APM development allowing them to partner with interested stakeholders. It is critical that specialty physicians, like SGO members, are involved in designing APMs to ensure that alternative ways of delivering services are relevant to specialty practice, not overly burdensome, and support the needs of our patients.

SGO believes value-based care delivery is critical in maximizing quality and cost effectiveness. Therefore, we are pleased that CMS continues to develop and test new models suitable for a wide range of practices of different sizes and specialties. Today, specialty physicians, like gynecologic oncologists, will find few physician-focused models available to them. We recognize that CMS intends to sunset traditional MIPS and move to MIPS Value Pathways (MVPs), and the agency is continuing to roll out new pathways each year. However, specialties like gynecologic oncology do not yet have MVP options to participate. Besides simplifying the MIPS program, the SGO strongly believes that all providers should have measures and MVPs that reflect the patient care they provide. Therefore, we encourage CMS to work with stakeholders like SGO to support and incentivize the development of specialty and subspecialty specific measures to make participation more meaningful for providers, Medicare beneficiaries, and the agency.

The administrative requirements and reporting processes associated with CMS' quality programs can feel burdensome for providers. This comes at a time when providers are also experiencing burdensome prior authorization requirements in the Medicare Advantage (MA) program. Improving the program, which covers nearly half of all Medicare beneficiaries, is imperative to ensuring that seniors receive the highest quality of care. Prior authorization processes require practices to realign staff or hire additional staff for the sole purpose of doing this work. This comes at a time when there are staffing shortages throughout the health care system and funneling resources from direct patient care to prior authorization duties is not in the best use of limited resources, while taking away time and energy from direct patient care. Additionally, SGO members are concerned that this process leads to delays in patient care, which is particularly concerning when a patient has cancer and time is of the essence, leading to negative health outcomes. One study found that 25 percent of gynecologic oncology patients experienced prior authorization during their cancer care with patients experiencing over a 2-week delay in care when prior

authorization occurred.[1] Reform is needed to reduce the burden of prior authorization in gynecologic oncology and SGO encourages you to review the prior authorization policies within the MA program to protect patient access to timely care.

Thank you for your leadership and interest in developing policy to stabilize the Medicare physician payment system to support providers and provide certainty for beneficiaries dependent on the program for their health care. We look forward to working with you to achieve these goals.

[1] Smith AJB, Mulugeta-Gordon L, Pena D, Kanter GP, Bekelman JE, Haggerty AE, Ko EM. Prior authorization in gynecologic oncology: An analysis of clinical impact. Gynecol Oncol. 2022 Dec;167(3):519-522. doi: 10.1016/j.ygyno.2022.10.002. Epub 2022 Oct 14. PMID: 36244827.