Medicare Payment Policy

REQUEST

The Coalition of State Rheumatology Organizations (CSRO) urges Congress to **extend financial relief to physicians facing steep reductions in Medicare reimbursement** and **explore options to stabilize the Medicare physician payment system long-term**. Specifically, we urge Congress to:

- Extend the 3% Medicare physician payment update into calendar year (CY) 2023;
- Avert statutory PAYGO sequestration (4%);
- Mitigate anticipated cuts to the CY 2023 conversion factor due to budget neutrality (3%); and
- Work with the physician community on long-term solutions to the broken Medicare physician payment system, including the addition of an appropriate inflationary index to reflect rising practice costs and authorizing the Secretary of Health and Human Services to waive, or modify, budget-neutrality requirements.

CSRO thanks Congress for mitigating reimbursement cuts resulting from a budget neutrality adjustment to the CY 2021 and 2022 Medicare Physician Fee Schedule (MPFS) conversion factors and temporarily suspending sequestration cuts. However, without additional congressional action, Medicare physicians again face a cumulative reimbursement cut close to 10% next year.

BACKGROUND

Medicare Conversion Factor. Changes to the codes for office and outpatient evaluation and management (E/M) services that the Centers for Medicare & Medicaid Services (CMS) implemented as a part of its CY 2021 MPFS final rule caused significant shifts in reimbursement across specialties and – due to budget neutrality – prompted a -10.2% reduction to the conversion factor. The *Consolidated Appropriations Act, 2021* modified the MPFS final rule by providing a 3.75% offsetting increase in MPFS payments for CY 2021, mitigating the negative impact on physicians. At the end of last year, the *Protecting Medicare and American Farmers from Sequester Cuts Act* mitigated cuts to the CY 2022 Medicare conversion factor by providing a 3% payment update. Changes to additional E/M services are expected to be included as part of the CY 2023 MPFS proposed rule and likely to result in another 3% reduction to the conversion factor.

Sequestration. In December 2021, legislation was signed into law to extend the moratorium on collection of the 2% Medicare sequester through March 2022, and to phase-in the 2% reduction until it is fully reinstated on July 1, 2022. In addition, the *American Rescue Plan* triggered the statutory *Pay-As-You-Go Act of 2010* and mandated Medicare spending reductions of an additional 4%, which was averted for one year but must be addressed before the next fiscal year. Absent congressional action, providers will see a combined 6% sequestration cut to Medicare reimbursement rates in CY 2023.

Long-Term Reform. As outlined above, Congress has been forced to step in several times over the last few years to avert significant, destabilizing reimbursement reductions in the MPFS. These temporary "patches" will be required until long-term payment reform occurs. The physician community – including CSRO – is eager to help Congress explore reform options to ensure that Medicare beneficiaries enjoy stable and continued access to the physicians they need.

CSRO urges Congress to **intervene to prevent the planned reductions in Medicare physician reimbursement that will become effective on January 1, 2023 and preserve Medicare beneficiaries' timely access to rheumatologic care by stabilizing the broken Medicare physician payment system**.

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Access to Prescription Drugs

REQUEST

The Coalition of State Rheumatology Organizations (CSRO) urges members of Congress to **protect patient access to medication by introducing transparency and correcting misaligned incentives in drug formulary construction; ensuring patients can receive the full benefit of copay assistance; and enacting commonsense guardrails around utilization management**.

BACKGROUND

Misaligned Incentives in Formulary Construction

Currently, prescription drug formularies are designed to maximize revenues for pharmacy benefit managers (PBMs), which explains how a $10,000 brand can gain formulary access while its $450 generic is not covered.[1] Similarly, the Office of the Inspector General (OIG) found that approximately a third of formularies in Medicare Part D excluded certain biosimilars from coverage even though they covered the reference products.[2] These formulary design decisions are disastrous for the patients who pay coinsurances based on list prices, particularly patients with high deductibles, who must shoulder their entire deductible with one prescription fill. Although the PBM industry claims that price concessions are used to reduce premiums, this claim is unverifiable since the industry operates in a black box. However, even if the claim were true, that would mean that sick patients with expensive medication needs are subsidizing the premiums for healthy patients. This is the opposite of how insurance is intended to work.

Recently, CSRO strongly urged the Federal Trade Commission (FTC) to conduct a comprehensive investigation of the business practices of the PBM industry, so we were pleased to see the Commission announce that it plans to do just that. **We urge Congress to enact policy solutions based on the findings of the FTC investigation.** Formularies must be constructed on efficacy, safety, and lowest list price, which removes kickbacks from the picture and creates a race to the bottom of pricing. At the very least, our system must: (1) pay middlemen a flat fee based on the market value of their services; (2) calculate patient cost-sharing based on the price reflecting all price concessions; and (3) ensure continued coverage for stable patients' medications, regardless of changes in formularies.

Protecting Patients' Ability to Use Copay Assistance

Patients with chronic conditions often need copay assistance to afford their medications. In recent years, many insurers and PBMs have excluded the value of cost-sharing assistance from counting toward a patient's deductible or annual limit through the use of "copay accumulators." In the *2021 Notice of Benefit and Payment Parameters (NBPP)*, the Centers for Medicare and Medicaid Services allowed insurers to use accumulators in the exchange markets unless a state law is in place to prohibit it. Biologics for autoimmune conditions have high out-of-pocket costs and most do not yet have a low-cost alternative. Thus, if patients cannot make full use of copay assistance, they will likely not fill their prescriptions. For conditions like rheumatoid arthritis, the consequences of non-adherence are irreversible.

The bipartisan *Help Ensure Lower Patient (HELP) Copays Act* (H.R.5801) would reverse the NBPP's harmful policy by prohibiting the use of copay accumulator programs in exchange plans and requiring insurers to apply the value of cost-sharing assistance toward an enrollee's cost-sharing requirements. **CSRO urges you to support the HELP Copays Act.** To cosponsor, please contact Naadiya.Hutchinson@mail.house.gov (Rep. Donald McEachin) or Janie.Costa@mail.house.gov (Rep. Rodney Davis).

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[1] "When the $10K brand name drug is more affordable than its $450 generic: How PBMs control the system" by Zachary Brennan, Endpoints News (Feb. 18, 2022).

[2] "Medicare Part D and Beneficiaries Could Realize Significant Spending Reductions With Increased Biosimilar Use" by Suzanne Murrin, Deputy Inspector General for Evaluations and Inspections, Office of Inspector General, U.S. Department of Health and Human Services (March 2022).

Reforming Utilization Management

Utilization management has become a serious issue for all patients, including Medicare beneficiaries. The Office of the Inspector General (OIG) examined denial rates in Medicare Part D and found that, in 73% of cases, denials were wholly or partially overturned when appealed, indicating that insurers leverage initial denials as a way to delay paying for medically needed care. Similarly, the OIG recently found that 13% of initial denials in Medicare Advantage actually met Medicare coverage rules. **CSRO urges Congress to enact commonsense reform of both prior authorization and step therapy protocols, as described below**:

- *The Improving Seniors Timely Access to Care Act* (S.3018/H.R.3173)
  Rheumatoid arthritis medications are subject to some of the most intensive utilization management requirements in healthcare, including prior authorization (PA) and step therapy. A recent study on prior authorization in rheumatology found that 71% of the studied patients required PA to begin their infused medications. Remarkably, 96% of all PAs – *including ones initially denied* – were ultimately approved, again indicating that PA serves more as a delay tactic than a meaningful "double-check" on clinical need.

  The bipartisan *Improving Seniors Timely Access to Care Act* would institute much-needed protections for patients by establishing an electronic PA process in Medicare Advantage, creating transparency around the processes used by insurers, ensuring that plans adhere to evidence-based medical guidelines and that requests are reviewed by qualified medical personnel, and minimizing the use of PA for routinely approved services.

  To cosponsor S. 3018/H.R. 3173, please contact Charlotte_Pineda@marshall.senate.gov (Sen. Roger Marshall), Sylvia_Lee@sinema.senate.gov (Sen. Kyrsten Sinema), Kyle.Hill@mail.house.gov (Rep. Suzan DelBene), or Sam.West@mail.house.gov (Rep. Mike Kelly).

- *The Safe Step Act* (S. 464/H.R. 2163)
  Step therapy requires a patient to try and fail one or more medication(s) preferred by the insurer before the patient can advance to the medication preferred by their treating clinician. Rheumatoid arthritis patients who switch plans often have to "step through" medications they have already tried and failed. Additionally, year-over-year formulary changes may result in stable patients having to switch medications, a practice called nonmedical switching. The American College of Physicians found that 40% of patients stopped treatment due to nonmedical switching.

  The bipartisan *Safe Step Act* requires employer sponsored plans to establish a clear, convenient, and readily available process to request step therapy exceptions, and establishes a timeline for appeals. The legislation also codifies exceptions to step therapy in five specific circumstances, including for stable patients and in situations where the treatment required by the step therapy protocol is contraindicated or expected to be ineffective for the patient.

  To cosponsor S. 464/H.R. 2163, please contact Angela_Ramponi@murkowski.senate.gov (Sen. Lisa Murkowski), Scott_Levy@hassan.senate.gov (Sen. Maggie Hassan), Erin.Doty@mail.house.gov (Rep. Raul Ruiz), or Casey.Quinn@mail.house.gov (Rep. Brad Wenstrup).