Public Health
Advisory Commission
of Alexandria, VA

PUBLIC HEALTH ADVISORY COMMISSION
Thursday, September 15, 2022
5:30 – 7:00 p.m.
Alexandria Health Department
Hybrid via Zoom and at 4480 King Street, 4th floor

I. Establishment of Quorum

II. Approval of the September 2022 minutes

III. Updates from the Chair

IV. Budget Items for City manager

V. Health Department Updates

VI. Medicare for All Update

VII. Public Comments

VIII. Adjournment

Commission Members
Chair **Andrew Romero**
Vice-Chair **Patricia Rodgers**
Dr. Jessica Hill
Allison Miner
Dr. Michael Trahos
Richard Merritt
JeanAnn Mayhan
Lisa Chimento
Melissa Riddy
Brian Hricik
Jacob Weinberg
Anita McClendon
Sylvia Jones

Alexandria Health Dept. Staff
Natalie Talis, Population Health Mgr.
Dr. David Rose Health Director
Casey Colzani Executive Secretary, Staff Liaison

Andrew Romero, Chair
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4480 King Street, Alexandria, VA 22302
703.746.4996

Public Health
Advisory Commission
of Alexandria, VA

Minutes of the Thursday, September 15, 2022
PHAC Meeting
5:30 – 7:00 p.m.
Hybrid - 4480 King St and Zoom
Alexandria Health Department

Present In-Person	Chair - Andrew Romero (AR), Patricia Rodgers (PR) Richard Merritt (RM), JeanAnne Mayhan (JM), Anita McClendon (AMC), Sylvia Jones (SJ) Allison Minor (AM), Brian Hricik (BH)
Present- Virtual	Dr. Michael Trahos (MT),
Absent (Excused)	Dr. Jessica Hill (JH) Melissa Riddy (MR), Lisa Chimento (LC), Jacob Weinberg (JW),
Absent (Unexcused)	
AHD Representatives	Casey Colzani (CC), Dr. Anne Gaddy (AG)
Guests	Jonathan Krall, Annemarie Yoder, Cedar Dvorin, Jennifer Olson, Jenny Yung

I. Establishment of a Quorum

- Meeting called to order at 5:35 pm by Chair Andrew Romero (AR) role taken.

II. Approval of the July 2022 Minutes

- Richard Merritt (RM) motioned to approve minutes, Brian Hricik (BH) second. All in favor, motion passed, minutes approved

III. Updated Electronic Meeting Policy

- Casey Colzani (CC) provided update on City Template for the updated electronic meeting, this expands the ability for limited fully virtual meetings.
- RM motioned to adopt new policy, BH second.
- Group discussed enacting policy, ensuring privacy for members who have health conditions (or family members); reminders were given about personal reason caps. P
- All in favor, the new policy will be adopted.

IV. Legislative Agenda Items

- Patricia Rodgers (PR) and RM submitted items in advance. City requested a ranking of items with multiple submissions
- RM- three recommendations from previously approved in the Advancing Racial and Health Equity by Reducing Tobacco Use and Exposure to Secondhand Smoke report and resolution.
    i. Recommends City Council advocate for an expansion of the state Medicaid tobacco cessation benefit;
    ii. Recommends City Council seek authority from the General Assembly to ban smoking in public spaces, including playgrounds, parks, bus shelters, and in-and-around city-owned and operated recreation facilities
    iii. Recommends City Council strongly encourage the General Assembly to ban the sale of menthol cigarettes or seek authority to restrict the sale of menthol cigarettes in the absence of a state-wide ban.
- RM motioned to include the above items in the legislative agenda submissions. BH Second Motion passes.
- PR submission:
    i. Consistent with the City Council Resolution 3087, which was adopted on June 28, we support any actions taken by the Virginia General Assembly that will protect the right to abortion services in Virginia, and ensure continued accessibility of reproductive and maternal and child health services for Virginians, particularly low-income residents of the Commonwealth.
- PR motioned to include her submission in the legislative agenda submission. RM Second.
    i. All in favor motion passed. BH abstained from vote on this item.
- Raking will be support for maternal, reproductive, abortion, and health services in VA and more comprehensive, affordable, and accessible smoking cessation benefits for enrollees in the Commonwealth's Medicaid program.

V. CHIP Update

- JM provided an update on the CHIP. The priority areas identified by the community are Housing, Mental Health, and Poverty
- JM has spoken with several members, to get feedback about how to further involve PHAC
- PHAC is a tactic owner on Mental Health, Housing, and Poverty.
    i. Small group work has begun with other tactic owners.
    ii. Will incorporate PHAC report, Eliminate Racial Disparities in Maternal and Infant Mortality in Alexandria in the PHAC work on Poverty. Report will be reviewed by 2 commission members, then will be presented to the full commission. Members will work with JM to establish a timeline of the subcommittee.

iii. Call for a representative on the housing workgroup- AR will further discuss housing- PR has attended Health Homes meetings in the past, and will connect with AR.

- Next Update will be in December

VI. Medicare for All Update-

- Jacob Weinberg (JW) was to provide an update but was not in attendance. Commissioners can still forward concerns and questions to JW. Members will check in with JW.

VII. Health Department Update

- Dr. Anne Gaddy provided AHD updates
- COVID Community level is Low- no current strain on healthcare or hospitals. Transmission still remains high. Bivalent boosters have been released- encourage everyone to receive the updated booster. This will help prevent a surge in infection in the fall.
- AHD Annual free Flu POD will be on October 15th, hoping to also offer Bivalent COVID boosters at the same event
- Monkeypox cases have plateaued. Continue to vaccinate all eligible individuals. Pulling staff from all areas to support these vaccinations. The citywide formation session was on September 14th. Available English, Amharic, Arabic and Spanish.
- Health Homes Initiative merging with Eviction Prevention Program.

VIII. Public Comment

- Jonathan Krall, with Grassroots Alexandria- Spoke to the commission about a coordinated effort to encourage City Council to make a resolution in support for Medicare for all. Group is looking to put a resolution to the council, looking for a letter of support of a resolution for single-payer health care, or a disinclination letter.
- Annemarie Yoder, Cedar Dvorin, Jennifer Olson, and Jenny Yung- attended virtually also in support of Medicare For All.

IX. Adjournment

- JM motioned for meeting adjournment, BH second. All in favor, meeting adjourned at 7:01 p.m.

Physicians' Medicare Pay Keeps Dwindling — How Bad Will It Get?

Leigh Page

August 19, 2022

John Ratliff, MD, a neurosurgeon at Stanford University, is tired of the way the Medicare program keeps paying physicians less and less.

Physicians are facing a planned 8.42% cut in Medicare reimbursements in 2023, which would be on top of a 2.75% cut in the second half of this year and a 3.3% cut in 2021.

"This constant cutting of Medicare rates, which has been going on for years, makes it hard for practices to make ends meet," said Ratliff, who chairs the Washington committee of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

Uncertainty about what the actual 2023 cut will be makes it hard for practices to plan ahead. At the end of this year, just before the cut is scheduled to go into effect, Congress might pare it back significantly, as it did the past 2 years. "These last-minute changes create a lack of stability and a lack of clarity for our practice environment," Ratliff said.

Will Congress step in again? The past last-minute fixes by Congress were seen as ways to protect physicians from the financial impact of the COVID-19 pandemic. But some policymakers think practices have now recovered and don't need another financial rescue.

"Medicare's payments for clinician services are adequate," stated the Medicare Payment Advisory Commission (MedPAC) in its March report. "We expect volume and revenue to rebound to pre-pandemic levels (or higher) by 2023."

A coalition of some 120 physicians' groups, including the American Medical Association (AMA), disputes that view and is calling for an overhaul of the way Medicare adjusts physician pay.

"The constant yearly fixes are ridiculous. It reminds me of the SGR," Ratliff said, referring to the sustainable growth rate, an automatic adjustment that menaced Medicare physician payments for the first one and a half decades of the 21st century. In all but 1 year, Congress stepped in to undo the yearly SGR cut, often weeks before it was due. The SGR was abolished in 2015, but the annual scenario seems to be back.

Hyperinflation in the economy will make Medicare pay cuts seem even steeper. In June, the general inflation rate stood at 9.1%, the highest level in more than 40 years, according to the US Department of Labor. In late spring, gas prices were up 43.6%, while prices for medical care rose just 3.2% over past year.

Although gas prices have recently been dropping, the rising gas prices have taken a toll on practices. "The gas price forced one person on my staff to quit," said David L. Holden, MD, an orthopedic surgeon in Oklahoma City. "She needed child care to come to work, and the cost of gas was so high she couldn't afford the child care anymore," added Holden, who is president of the Oklahoma State Medical Association.

According to Holden, continued Medicare payment cuts could lead to access problems for patients. "If reimbursements continue to drop, more doctors will have to cut back on Medicare or even drop it," he said.

A Long-Term Slide in Medicare Payments

"The problems physicians are having with Medicare cuts are not new. We have been experiencing them for more than two decades," said Parag D. Parekh, MD, an ophthalmologist in State College, Pennsylvania, and chair of government relations at the American Society of Cataract and Refractive Surgery.

From 2001 to 2020, the cost of running a practice rose 39%, but Medicare payments, adjusted for inflation, fell by 50%, according to the Surgical Care Coalition, a group of surgical societies that opposes the Medicare cuts.

Even without accounting for inflation, Medicare reimbursements for doctors are at the same level as two decades ago. The Medicare conversion factor, a multiplier used to convert relative value units (RVUs) into the reimbursement amount, stood at $36.69 in 1998, and this year it stands at $34.60, the coalition reports.

"Medicare payments to hospitals have a 2% yearly increase built in, but doctors don't have that," said Ezequiel Silva III, MD, a San Antonio, Texas, radiologist who chairs the Relative Value Scale Update Committee, operated by the AMA.

This may also be due to the unique position the SGR put physicians in. The SGR was supposed to regulate physician fees. When Congress abolished it in 2015, it transitioned physicians to value-based payments, which basically reward them for saving money for Medicare. This is done either through the Merit-Based Incentive Payment System or Advanced Alternative Payment Models (APMs).

After the SGR was abolished, physicians received modest yearly increases of 0.5% or less for 5 years, but, owing to other factors, actual reimbursement was lower than that amount. Since 2020, physicians have received no updates at all. In 2026, an even more modest increase of 0.25% is scheduled to begin.

Working Harder to Compensate for Lower Payment

"As physicians saw the real payment for their work decline, the answer often was, 'All right, I'm going to work harder,' but you can only work so much harder," said Brian Larkin, MD, a hip and knee surgeon at Orthopedic Centers of Colorado in Denver.

Larkin added that doctors have had to become more efficient, but they are often not rewarded for that by Medicare. "I have been doing hip and knee replacements in a very efficient, cost-effective way," he said. He has been participating in Medicare's Comprehensive Care for Joint Replacement Model, which has been rewarding hospitals for improved cost efficiency. But Larkin said the program did not reward doctors for using markedly less expensive ambulatory surgery centers rather than hospitals.

Through his value-based activities, Larkin had hoped to qualify for Medicare's APM program, which would have rewarded him a 5% bonus. To qualify, however, he would have needed to have received at least 50% of his Medicare payments or to have 35% of his Medicare patients on a qualifying APM, but Larkin said not enough Medicare programs are available to reach that level.

"APMs sound good on paper, but they don't have practical meaning in terms of benefiting providers," Larkin said. His concerns about getting the 5% bonus will soon be moot, however, because 2022 is the final year to qualify for it.

The Perils of More Congressional Cuts

CMS sets Medicare reimbursement each year, but Congress has been adding reductions to the CMS cuts. CMS has proposed a 4.42% cut for physicians in 2023, but the expected cut is actually 8.42% because an automatic 4% cut goes into effect when federal spending reaches a certain level. This cut is directed by Congress through the Statutory Pay-As-You-Go (PAYGO) Act of 2010.

PAYGO cuts were triggered by the American Rescue Plan Act of 2021, a $1.9 trillion package to offset the effects of the COVID-19 pandemic. If allowed to go through, the 4% PAYGO cut would affect all discretionary spending by the federal government, not just Medicare. These cuts were supposed to start in 2021, but Congress set them aside for 2021 and 2022.

Will Congress set PAYGO aside for 2023? Interest groups on Capitol Hill, including physicians' groups, are asking for another year's deferral, but PAYGO cuts will probably occur sometime in the future.

Another congressionally mandated cut is not counted in the 2023 cuts because it went into effect in 2022 and therefore is not considered a new cut. The Medicare sequestration is a 2% cut on all Medicare payments, not just those for physicians.

The 2% Medicare sequestration cut was in effect from 2012 to 2019, but Congress set it aside in 2020 and 2021 because of the pandemic. It phased it back in for this year. Is the Medicare sequestration here to stay, or can Congress be convinced to set it aside again?

"Now is a bad time for cuts, when inflation is so high and we just came out of a pandemic," said Issada Thongtrangan, MD, a solo orthopedic spine surgeon in Scottsdale, Arizona. "Practice costs are going up and they keep cutting reimbursements."

What Lies Ahead

Physician groups want Congress to go beyond simply overriding planned cuts every year. "Unless there is a fundamental change in the payment system, Medicare physician pay will likely be cut every year into the foreseeable future," said George Williams, MD, an ophthalmologist in Royal Oak, Michigan, who is a spokesperson for the American Academy of Ophthalmology.

Budget neutrality, as it exists now, produces cuts whenever the value of services is significantly changed. The AMA is calling on Congress to "eliminate, replace, or revise budget-neutrality requirements to allow for appropriate changes in spending growth."

The AMA also wants physicians to have a reliable payment update. "The physician payment system needs to provide predictable and dependable annual increases that take into account inflation and rising practice costs," said Jack Resneck, Jr, MD, a San Francisco dermatologist who is the 2022–2023 AMA president.

Furthermore, the AMA wants physicians to be able to participate in Medicare payment models that "recognize physicians' contributions in providing savings and quality improvements, such as preventing hospitalizations," according to an AMA report.

In Resnick's words, "Physicians are extraordinarily dissatisfied with the way Medicare pays them."

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THE MEDICAL SOCIETY OF NORTHERN VIRGINIA

Fall/Winter 2007

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Message from the President

Michael C. Trahos, D.O.

Greetings fellow colleagues. As the 2008 elections approach, political candidates have initiated debates concerning Healthcare Reform. As we are all aware, Healthcare Reform is a multifaceted issue. In the two previous MSNVA Newsletters, I have addressed the related matters of Judicial Tort Reform and Medicare reimbursements. In this installment, I will discuss the largest issue in Healthcare in need of reform, the health insurance industry. To exemplify the public's misconception regarding this issue, I will relate a story that involves my son.

My son, Christopher, is currently attending the Georgetown University McDonough School of Business. Last spring, he was taking an international business course in which a discussion arose concerning the excessive healthcare costs large companies, such as Ford and General Motors (GM), were incurring for both their current employees and retirees, and how these costs were as much as 60% of their operating budget. In my discussions with Chris, it became apparent to me he was of the belief these healthcare costs were directly attributable to the charges incurred by healthcare providers. I then asked him a simple question; "Chris, if a GM employee was to come to my office for medical care, is it GM that pays me directly for the office visit?" Looking at me with a degree of confusion, I explained to him it is not GM that pays me directly for the office visit, but an insurance company who has been contracted by GM to administer the healthcare costs of their employees and retirees. What my son and the public are failing to understand is the major component to the supposed crisis in the cost of healthcare in the United States is not necessarily because of the charges incurred by healthcare providers, but instead a Health Insurance Underwriting crisis and the exorbitant profits made by the Health Insurance Industry through the administration of health insurance premiums.

There have already been proposed radical solutions to the Health Insurance Underwriting crisis such as the "Single Payer Model" and government run "Socialized Medicine." I believe Health Insurance reform is still best achieved through this country's "free market system." However, any Health Insurance reform must be predicated with the understanding that "windfall profits" cannot be permitted by non-medical third parties, such as stockholders and corporate executives, as a result of the administration of health insurance premiums. You may then ask, "How is this possible?" The proposed solution is relatively simple.

To begin, a single non-for-profit corporation is created for the sole purpose of becoming the "central repository" of all private sector insurance premiums; that is all non-Medicare/ Medicaid insurance premiums are sent to one non-governmental national location for deposit. The United States is then divided into medical Geographic Service Areas (GSAs), based upon population densities, as has already been done by governmental entities such as the Federal Communications Commission (FCC) and the Centers for Medicare & Medicaid Services (CMS). What comes next is "capitalism at its best," the implementation of "Competitive Bidding," that is auctioning, amongst Health Insurance companies for the "privilege" of the administration of health insurance premiums deposited into the "central repository."

In this capitalistic "free market system" of "Competitive Bidding," participating Health Insurance companies enter into a "bidding war" for the lowest price they are willing to administer health insurance premiums within these GSAs. The reward to the winning bidder is tremendous, for that entity is given exclusivity to that GSA market and all the beneficiaries therein.

(continued on page 6)

News Briefs

Politics! Politics! Politics!

Bruce Lucero, M.D.
Pres-Elect, MSNVA

The success of a restaurant may depend on "Location! Location! Location!," but it is Politics! Politics! Politics that will determine the success of healthcare and a physician's practice as we know it.

MSNVA with the support of its membership and guidance of the MSNVA Board is stepping up in the Political Arena.

In October, MSNVA cosponsored with Northern Virginia Bar Association (this is a group of attorneys from all areas and is different from the Trial Lawyers Association) to have a Meet the Candidates Forum at the Fairview Marriott. It was attended by most major Candidates and Incumbents in our legislative area of Northern Virginia. MSNVA had over 35 doctors represent us there. This was a significant number of Doctors that were well received by the Legislative Candidates and Incumbents. By our strong turnout, we were recognized as being more politically involved...with issues...with agendas...that need to be addressed. The Candidates and Incumbents saw us make a strong statement, that we Doctors in MSNVA are organized and willing to work to make a "Political" difference.

Additionally, MSNVA sponsored a Resolution to make a little known and somewhat inactive program "Physicians On Call" a priority. We are pleased to announce it was adopted by MSV at the Annual Meeting in October. "Physicians On Call" is a program by MSV/VAMPAC to develop, coordinate, educate, train, and designate small groups of physicians in each legislative district to meet several times per year with their respective Legislators for the purpose of educating Legislators on the complex issues of Healthcare. "Physicians on Call" will also coordinate with MSNVA's Political Steering Committee. By making "Physicians On Call" a priority, Virginia doctors should be able to better educate Legislators as well as increase access and support of other Legislators across the State.

We are excited and look forward to working with Family Practice Physician Joe Leming, in his announced bid for Lieutenant Governor for Virginia 2009. Among his many accomplishments, Dr. Leming has been elected Speaker for MSV and Chairman of the Board of Supervisors for Prince Georges County, Virginia. Dr. Leming is expected to attend MSNVA's annual meeting in December. This will be a great chance for our membership to get to know Dr. Leming.

MSNVA also compiled and sent a comprehensive list of local Candidates and Incumbents in the State Legislature to assist the decision process of the membership on election day. We encourage our membership to retain this list and contact their Legislators as issues come up. If you need another copy, please contact us at MSNVA.

Michael Trahos, D.O. & Daniel H. Ruttenberg
President, Fairfax Bar Association

Ednan Mushtaq, M.D., David Chow, M.D. & Sen. Richard Saslaw

(Message from the President continued from cover)

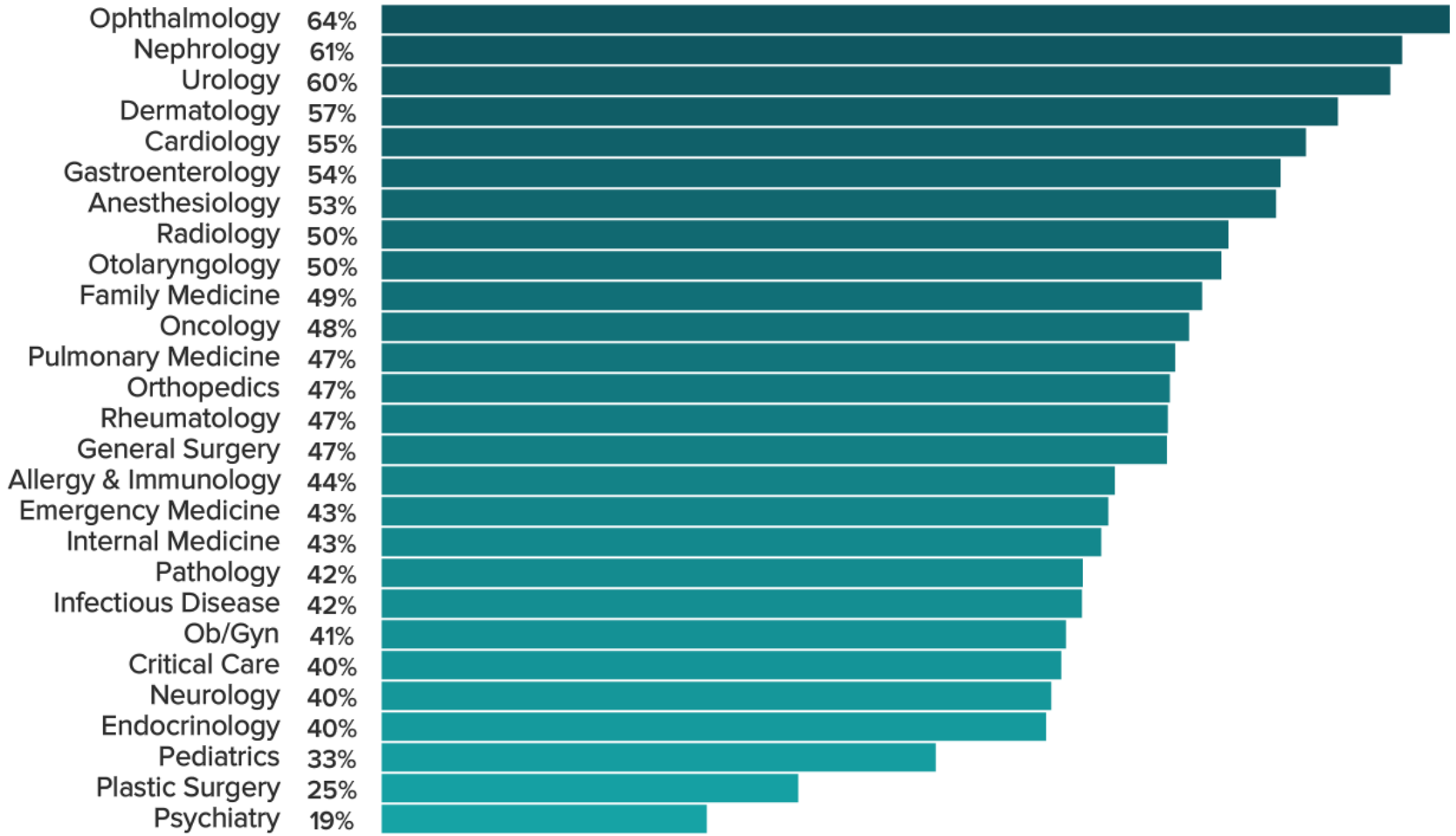
Likewise, it is also a "win-win" situation for the beneficiaries and healthcare providers. Since there are no "windfall profits" going to stockholders and corporate executives, said profits would then be split 50%-50% between the beneficiaries, in the form of significant reductions in base insurance premium rates, and the healthcare providers, in the form of substantial increased reimbursements to physicians who participate with the winning entity of that GSA. Also, and as a direct result of lower insurance premium costs, a significant number of the supposed "uninsured" in this country suddenly become insured.

This Health Insurance Underwriting reform proposal is, however, dependent upon Congress having the intestinal fortitude to pass legislation enacting this proposal. Will a yet to be elected 2008 United States President and Congress truly and legislatively enact meaningful Health Insurance Underwriting reform, or will our elected officials maintain the "status quo" and remain the "puppets on the strings" of the Health Insurance Industry able to manipulate them at will. Only until the President and Congress is willing to cut the "puppet strings" of the Health Insurance Industry, coupled with Professional Liability Insurance (PLI) Underwriting/Judicial Tort reform and Medicare reimbursement reform, will the United States of America see meaningful Healthcare Reform, with the uninsured becoming insured, and the delivery & rendition of the highest quality healthcare ensured to all the citizens of this country.

Lastly, as my Presidency of the Medical Society of Northern Virginia concludes, I remain humbled and honored at the opportunity of having served as your President. I wish to thank the MSNVA Board of Directors for their hard work this past year. I further wish to thank the MSNVA staff and in particular John Richards, our Executive Director, for their endless hours of devotion to our society and its membership. It has been an absolute pleasure working with you and God bless you all.

Physicians Who Expect to Participate in MACRA

(MACRA = Medicare Access and CHIP Reauthorizations Act of 2015)



Advocacy Alert: Tell Congress to Address Looming Medicare Cuts

In December 2021, through your advocacy efforts, the AOA was able to work with Congress to pass the *Protecting Medicare and American Farmers from Sequester Cuts Act*, which provided a temporary 3% positive adjustment to the Medicare Physician Fee Schedule (MPFS) conversion factor (CF) for 2022. This partially counteracted the scheduled payment reduction and averted an additional 4% Medicare payment cut due to statutory pay-as-you-go (PAYGO) requirements.

However, absent Congressional action, physicians participating in Medicare will face another round of significant payment cuts, totaling to nearly 9 %, which will take effect on January 1, 2023. These significant cuts have consequences to senior's access to healthcare and could be detrimental to independent physician practices that are no longer able to absorb such financial losses.

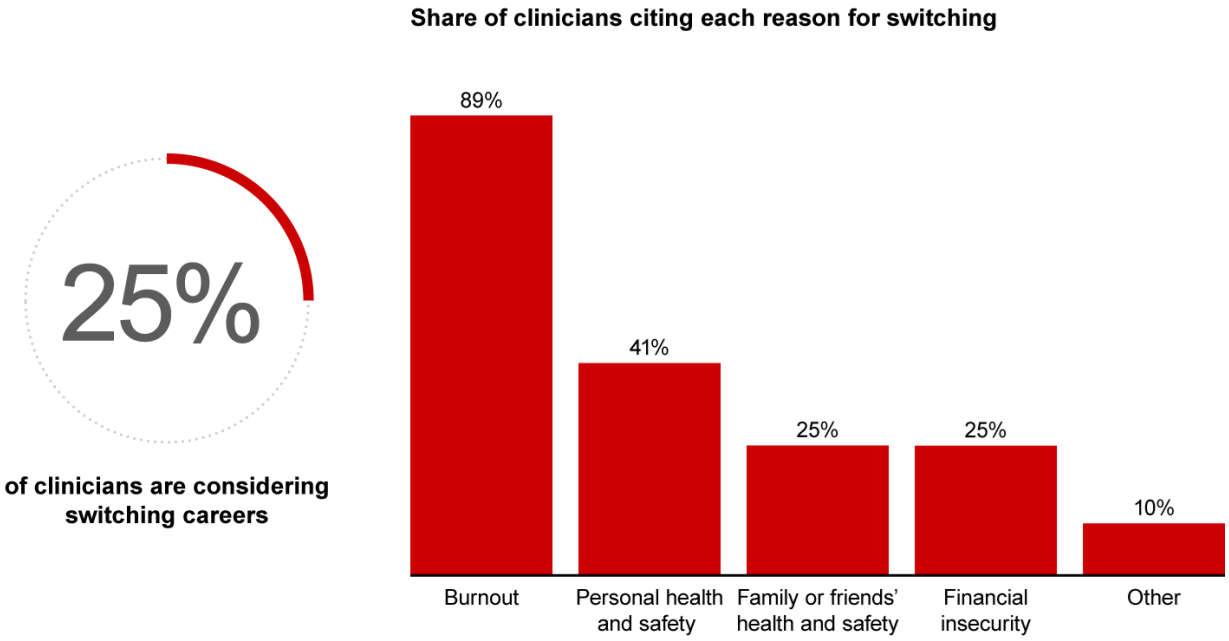
A Treatment for America's Healthcare Worker Burnout

A quarter of US clinicians are considering switching careers. Leading providers will combine immediate actions with longer-term investments to combat attrition and improve well-being.

By Erin Ney, MD, Michael Brookshire, and Joshua Weisbrod

BAIN & COMPANY

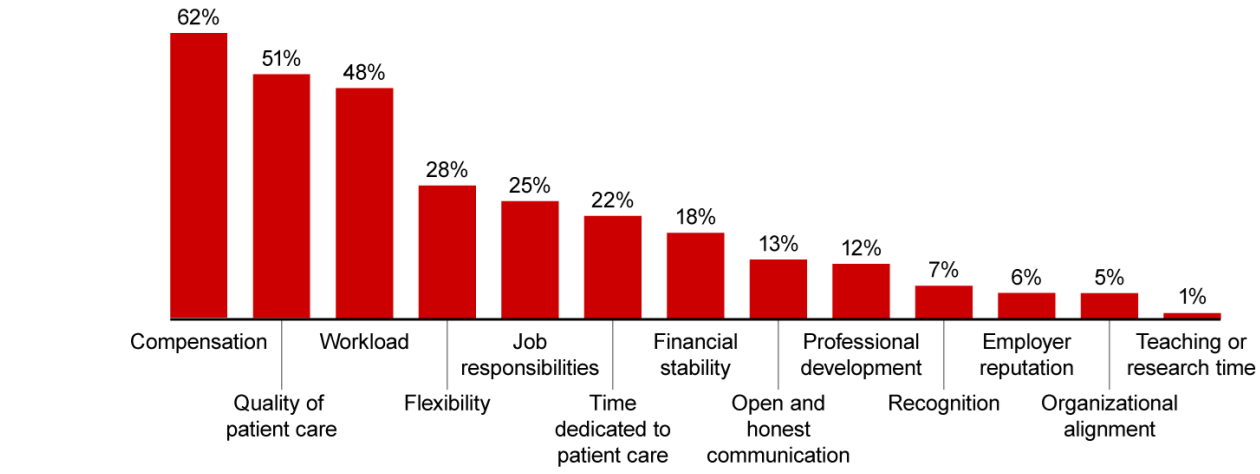
25% of Medical Providers Now Want OUT OF MEDICINE



Note: Clinician results are an aggregate of responses from physicians, nurses, and advanced practice providers
Source: Bain US Frontline of Healthcare Survey, July 2022 (n=573)

Compensation #1 Reason for Now Wanting OUT OF MEDICINE

Share of clinicians ranking each item among their top three most important criteria



Notes: Physician responses are weighted by specialty against the US physician population; nurse and advanced practice provider responses are not weighted by role
Source: Bain US Frontline of Healthcare Survey, July 2022 (n=573)