

September 19, 2023

The Honorable Bernie Sanders  
Chair  
Health, Education, Labor, and Pensions  
Committee  
United States Senate  
Washington, DC 20510

The Honorable Roger Marshall, M.D.  
Ranking Member  
Subcommittee on Primary Health and  
Retirement Security  
United States Senate  
Washington, DC 20510

Dear Chair Sanders and Subcommittee Ranking Member Marshall:

On behalf of the Association of American Medical Colleges (AAMC), I write in response to your announcement of the Bipartisan Primary Care and Workforce Act. The AAMC appreciates your continued commitment to expanding and diversifying the health care workforce and recognizes your strong engagement with us on these issues. Your efforts to expand the health care workforce to address projected shortages is something on which the AAMC is committed to working, and I applaud your efforts in that regard. I write today, however, to express deep concern with counterproductive proposals included in the legislation that would jeopardize patient access to care, drastically cut payments to teaching hospitals and health systems, weaken the nation's public health infrastructure, and ultimately harm the patients and communities our members serve.

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 12 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The AAMC appreciates your longstanding leadership, focus, and dedication to health care workforce issues, and in particular the legislation's needed investments in the National Health Service Corps (NHSC), Minority Servicing Institutions (MSIs), Historically Black Colleges and Universities (HBCUs), and Teaching Health Center Graduate Medical Education (THCGME), and provisions to reauthorize the Health Resources and Services

Administration (HRSA) Title VII and Title VIII health professions and nursing education and training programs, expand rural physician training, and make enhancements in telehealth. Clearly, our partnership on workforce issues has resonated as it relates to those key priorities, and we believe this area of the legislation stands to positively impact the health care workforce.

However, we have serious concerns with several policies included in the legislation that would significantly impact the nation's teaching hospitals and health systems, jeopardize patient access to care, and weaken public health infrastructure. AAMC's member teaching hospitals and health systems are key pillars of communities across the country, and we cannot address health care workforce issues at their expense. Our concerns are discussed below:

### **Title III, Section 301**

The AAMC is opposed to Section 301, which would impose unnecessary federal interference in contracting negotiations between teaching hospitals and health systems and insurers. Contract negotiations are complex discussions that involve nuanced considerations related to compromises, payment amounts, patient types, volume, services, and many other variables – each of which is connected to a dollar amount and subject to negotiation. Both providers and insurers use specific contractual language to modify these variables to reach an agreement that is mutually acceptable to all parties.

Eliminating the ability of providers to use the contracting tools outlined in Section 301 would give insurers an unfair advantage in these negotiations. As you know, insurers continue to consolidate and wield historically high market power, at times being the sole, or one of the only insurers in a particular area. This threatens to diminish hospitals' ability to fairly structure contracts, and stands to intensify consolidation and continue to inflate insurer margins while harming the very entities who are delivering patient care.

Anti-tiering, anti-steering, and all-or-nothing clauses, at their core, protect patient access to care by ensuring a more level negotiating environment between providers and insurers. While the Affordable Care Act did contain several network adequacy provisions, insurers consistently manipulate and devise narrower networks in the name of lower costs. Under these circumstances, where premiums continue to rise and provider networks shrink, patients pay the ultimate price, as they incur higher costs for reduced health care access. The contracting tools outlined in Section 301 help prevent insurers from creating networks that exclude teaching hospitals and health systems and their faculty physicians, thus helping to ensure heightened patient access to the high-quality and comprehensive care that our members provide. Narrow networks put the health of patients at risk and increase costs to the patient should they seek or require out-of-network care at teaching hospitals.

Teaching hospitals and health systems have focused more on delivering care in the community. These care settings are critical to meeting patients' needs beyond the walls of a traditional inpatient hospital. However, this also means that teaching hospital and physician care settings are more decentralized and must absorb the costs of operating these additional facilities. Allowing insurers to pick and choose which parts of a hospital system to include in

the network gives them significant contracting leverage as they will be able to cherry-pick facilities. An insurer may deem certain individual sites to be “cheaper” with no consideration to the quality of care, or accessibility of services to a particular community.

Teaching hospitals and health systems know best the distinct characteristics of the patient populations they serve. Consequently, they must retain flexibility to negotiate the contractual terms that best meet the needs of those patient populations.

### **Title III, Section 302**

While the AAMC supports transparency in health care, we are concerned that Section 302 of this legislation would impose additional administrative and financial burdens on our member teaching hospitals and health systems. This provision would require both a separate identification number and an attestation for each hospital outpatient department (HOPD). Teaching hospitals and health systems are complex entities that must already dedicate substantial financial resources to billing. This provision would require hospitals to invest additional resources to update their billing and IT systems and reorganize workflows to comply with these new regulations, resources that would be better allocated to patient care. AAMC-member teaching hospitals and health systems are already facing immense financial pressures; therefore, complying with additional and unnecessary reporting requirements only stands to further squeeze hospitals and jeopardize patient access to care.

### **Title III, Section 303**

The AAMC is deeply concerned with the drastic payment cuts to teaching hospitals and health systems proposed in Section 303. This provision would bar health care facilities from charging a facility fee for telehealth or evaluation and management services. This provision ignores the importance of facility fees to help offset the costs of providing care and the very real and increasing costs of maintaining facilities, retaining staff, and investing in technology.

Cuts to teaching hospitals and health systems would undoubtedly impact access to care for patients and communities and endanger teaching hospitals and health systems' ability to provide and coordinate health care services that are frequently unavailable at other providers, especially to under-resourced patients and communities. For teaching hospitals and health systems and their faculty physicians, the costs of delivering services in HOPDs are fundamentally different from other sites of care because hospitals must have standby capacity for disasters and public health emergencies, remain open 24/7 to deliver emergency care, and are required to provide care to all patients coming to the emergency room. HOPDs also must comply with greater licensing, accreditation, and regulatory requirements than physician offices. Hospital-based clinics provide services for low-income and underserved patient populations that may not be available anywhere else in the community. The elimination of agreed-upon reimbursement would undoubtedly impact access to care for patients and communities and endanger teaching hospitals and health systems' ability to provide and coordinate health care services that are frequently unavailable to under-resourced patients and communities.

Although it may be safe for some patients to receive a particular type of service in a freestanding physician's office, it is not safe for all patients. For safety reasons, socially and medically complex patients often receive services in HOPDs, which are better equipped to handle any complications and emergencies that may arise during treatment. For this reason, physicians will often refer their most complex patients to HOPDs for treatment. For example, if a patient suffers from comorbidities, faints during the administration of chemotherapy in a physician's office, or has an allergic reaction to a medication, the next time they undergo the procedure, their physician would most likely recommend that the patient receive care at an HOPD. Given the complexity of the patients treated, as well as additional administrative and regulatory standards HOPDs are held to, it is more expensive for HOPDs to treat patients. Implementing the payment restrictions proposed by Section 303 could result in HOPD closures, thereby reducing access to care for Medicare beneficiaries and other patients who require these services.

HOPDs also play an important role in clinical training for medical students, residents, and other trainees. As a result of these proposed cuts, HOPDs may be forced to reevaluate, reduce, or eliminate service lines, which would result in less exposure to primary care and ambulatory services for these trainees, as well as reduced access to care for the patients and communities they serve.

Additionally, Congress and stakeholders have acknowledged the importance of expanding access to telehealth care. As a result of critical COVID-19 pandemic policies, patients nationwide benefited from increased access to telehealth services. Congress' work to expand telehealth services to more people in rural, urban, and other underserved communities would effectively be undermined by eliminating critical financial support. Payment for telehealth services must account for practice-related expenses, which are generally the same regardless of whether the encounter is in person or virtual, as virtual services increase technology expenses that balance (or exceed) reduced supply expenses. In both cases, support staff are critical for patient experience. These expenses support the billing of an originating site fee, as is currently covered under Medicare, where the patient is present in the HOPD receiving telehealth services from a distant site provider.

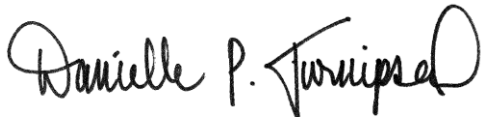
### **Title III, Section 304**

The AAMC has deep concerns with the proposed cut to the Prevention and Public Health Fund (PPHF) and its consequences on the nation's public health infrastructure. The PPHF currently supports more than 10 percent of the Centers for Disease Control and Prevention's annual operating budget and supports a variety of essential public health and clinical prevention programs that improve the nation's health. As I am sure you would agree, decades of underfunding at the local, state, and national levels already have substantially undermined the nation's public health infrastructure and strained foundational public health capabilities. Layering another cut to the PPHF – and, by extension, to the CDC – would only further weaken the nation's public health infrastructure and undercut future opportunities to strengthen the nation's health.

Again, we appreciate your commitment to the health care workforce and welcome the opportunity to continue working with you to address health care challenges facing our

country. It is imperative that we make progress on health care workforce issues, but not at the expense of teaching hospitals and health systems in our communities. If you have any further questions, please contact my colleagues Leonard Marquez, Senior Director of Government Relations & Legislative Advocacy ([lm Marquez@aamc.org](mailto:lm Marquez@aamc.org)) or Tannaz Rasouli, Senior Director of Public Policy & Strategic Outreach ([trasouli@aamc.org](mailto:trasouli@aamc.org)).

Sincerely,

A handwritten signature in black ink that reads "Danielle P. Turnipseed". The signature is written in a cursive style with a large, looped initial 'D'.

Danielle Turnipseed, JD, MHSA, MPP  
Chief Public Policy Officer  
Association of American Medical Colleges

CC: David J. Skorton, MD  
President and CEO  
Association of American Medical Colleges