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October 4, 2023

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Re: AAMC Response to Request for Information on "Improving Access to Health Care in Rural and Underserved Areas"

Dear Chairman Smith:

On behalf of the Association of American Medical Colleges (AAMC), I write to respond to your Sept. 7 request for information (RFI) on "Improving Access to Health Care in Rural and Underserved Areas." The AAMC appreciates your attention to this important issue, as caring for rural and underserved communities and improving their access to care is a fundamental component of our members' mission to improve the health of people everywhere.

The AAMC 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 and its member teaching health systems, hospitals, and faculty physicians are committed to delivering high-quality, comprehensive patient care in all communities across the United States. For decades, health care providers and policymakers have remained concerned with health and health care in rural and underserved areas, particularly in light of physician and other provider shortages, inadequate reimbursement, hospital closures, limited access to care, and the higher numbers of poorer, sicker individuals compared to urban areas. Accessing quality health care in rural communities can be a challenge. According to a newly published issue brief entitled "Rethinking Rural Health" by the AAMC Research and Action Institute, rural areas tend to struggle more with the recruitment and retention of physicians and other key health care

workers. These workforce issues often result in gaps in care, particularly in specialties, forcing patients to travel farther distances to access care.[1]

To address challenges facing rural patients and communities, AAMC-member institutions are developing creative solutions to help ensure that enough physicians are serving rural communities and that all patients have access to affordable, high-quality care when they need it. Some of these solutions include partnerships with rural teaching hospitals for training opportunities, investments in mobile clinics to serve more patients in need, and student loan forgiveness programs to lessen students' financial debt while increasing the likelihood they practice in rural areas. We welcome you to read more about these specific efforts in the AAMC's new brochure: *How Academic Medicine Serves Rural Communities Across the Country*.

More must be done, however, to improve rural access to care, and the federal government can play an important role in these efforts. The AAMC appreciates your interest in this issue and submits the following recommendations for your consideration:

Geographic payment differences

- Consider Medicare wage index reforms

Sustainable Provider and Facility Financing

- Increase Medicare payment rates
- Avert Medicare Physician Fee Schedule Cuts for 2024
- Reform the Medicare Physician Fee Schedule and pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474)

Aligning Sites of Service

- Reject proposals to implement so-called site-neutral payment cuts

Health Care Workforce

- Build upon historic bipartisan progress and pass the Resident Physician Shortage Reduction Act (H.R. 2389), which would responsibly increase the number of Medicare-supported graduate medical education (GME) positions
- Better equip rural teaching hospitals to apply for new Medicare-supported GME positions
- Provide initial resources for Rural Track Programs
- Reduce administrative burden on hospitals and physicians to reduce burnout and the early exit of physicians and other health care providers from the workforce

Innovative Models and Technology

- Ensure the continued move to value-based care by passing the Value in Health Care Act (H.R. 5013)
- Make key COVID-19 telehealth flexibilities permanent
    - Allow payment for telehealth services in all geographic locations, including the patient's home

[1] Orgera, Kendal, Senn, Siena, and Grover, Atul. "Rethinking Rural Health." AAMC Research and Action Institute, Sept. 27, 2023: https://www.aamcresearchinstitute.org/our-work/issue-brief/rethinking-rural-health

  - Allow payment for audio-only telehealth services
  - Allow physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), and audiologists to provide telehealth services
  - Allow payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for telehealth services
  - Allow virtual supervision of residents for telehealth and in-person services in all geographic locations
- Remove in-person visit requirements for mental health services
- Promote the use of interprofessional consults and eliminate barriers
  - Remove barriers to uptake & sustainability of interprofessional consults
- Increase access to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM)
  - Allow less than 16 days of monitoring within a 30-day period for RPM and RTM services

Geographic Payment Differences

Consider Medicare wage index reforms

The AAMC encourages you to consider the recent recommendations by the Medicare Payment Advisory Commission (MedPAC) in Chapter 9 of their June 2023 report to Congress.[2] In the report, MedPAC recommended that Congress "repeal the existing Medicare wage statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals."[3] The Medicare wage index has long-standing inequities and inaccuracies that worsen as time goes on. We urge Congress to ensure that wage index systems reflect local area-level differences in wages between and within metropolitan statistical areas and statewide rural areas.

Sustainable Provider and Facility Financing

Increase Medicare payment rates

The AAMC remains strongly concerned that Medicare payment rates do not adequately reflect the significantly higher growth in labor and supply costs that hospitals have experienced as a result of record inflation and the COVID-19 public health emergency (PHE). In its March 2023 report to Congress, MedPAC notes that "hospitals' Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals' input costs, which exceeded the forecasts the Centers for Medicare & Medicaid Services (CMS) used to set Medicare payment rate updates."[4] Further, recent reporting indicates that labor costs are 19 percent higher year-to-date in March

[2] Medicare Payment Advisory Commission. June 2023 Report to Congress. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_MedPAC_Report_To_Congress_SEC.pdf
[3] Ibid.
[4] Medicare Payment Advisory Commission. March 2023 Report to Congress. https://www.medpac.gov/wpcontent/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf

2023 as compared to March 2020.[5] It is not expected that these cost trends will lessen in the coming year or the foreseeable future.

CMS continues to provide inadequate market basket updates for provider payments due to its reliance on forecasts rather than actual historical labor and supply cost increases, and this fails to acknowledge and incorporate the challenging circumstances brought on by the pandemic. Therefore, using the current methodology to calculate the payment update inaccurately estimates the financial strain hospitals have experienced and will continue to experience in FY 2024 and is insufficient to address these cost increases. Action is needed to ensure adequate updates to the market basket, particularly in light of the exceptional circumstances our members are facing – including increased labor costs, which are expected to remain, and the continued financial struggles of hospitals as they try to maintain access to services. The AAMC and other organizations have called on CMS to remedy errors in their market basket calculations, and we believe that Congress, too, should require this action.[6]

Avert Medicare Physician Fee Schedule Cuts for 2024

The proposed 2024 Physician Fee Schedule (PFS) rule sets forth the dollar conversion factor that would be used to update payment rates for participating physicians. This update has, again, resulted in a conversion factor (CF) for 2024 that will reduce payments to physicians. While the PFS is in dire need of an overhaul, Congress must intervene to mitigate the proposed cuts to physician payments. In 2024, not only will there be a 3.6 percent reduction in the CF, but physicians are also facing a statutory freeze in annual Medicare PFS updates until 2026, when annual updates will resume at a rate of only 0.25 percent for clinicians not in advanced alternative payment models (APMs) and 0.75% for those participating in advanced APMs well below the rate of inflation.

We are deeply concerned about the impact of these significant cuts. Payment reductions of this magnitude would pose a major problem at any time, but to impose these cuts when teaching physicians and other health care professionals are still recovering from the financial impact of the COVID-19 pandemic, experiencing increasing workforce shortages, and weathering record-setting inflation and rising practice costs, will be extremely harmful. Prior to the pandemic, there were major concerns about physician well-being, and the pandemic, financial pressures, and administrative burdens only increased those concerns. The AAMC urges Congress to mitigate the CY 2024 PFS cuts and to help preserve the existing physician workforce.

Reform the Medicare Physician Fee Schedule and pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474)

Physician payments have failed to keep pace with rising inflation and practice costs. An analysis by the American Medical Association (AMA) found that from 2001 to 2023, Medicare physician payments have increased only nine percent, while the cost of running a medical practice has increased 47 percent.[7] The AAMC is concerned that the additional reductions in revenue for physicians combined with workforce shortages could result in even greater access problems for

[5] Kaufman Hall, "National Hospital Flash Report," April 2023, https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf.
[6] AAMC Letter to CMS on FY 2023 IPPS, June 2023: https://www.aamc.org/media/68321/download?attachment
[7] AMA Snapshot, Medicare updates compared to inflation (2001 – 2023) (2023)

patients, including those in rural and other underserved communities. Continued cuts to physician payment will further strain the physician workforce and are likely to trigger further early retirement or reduction in physician services during a time when physicians are needed the most in their communities. According to the AAMC's projections, by 2034 the country could experience a shortfall of up to 124,000 physicians.[8] These shortages may be exacerbated if physicians face these cuts in payment.

MedPAC agrees that Medicare physician payment should be increased, and recommended this year that Congress increase the 2024 Medicare physician payment rate above current law with an inflation-based payment update tied to the Medicare Economic Index (MEI). According to MedPAC, of those Medicare beneficiaries looking for a new primary care physician, half had difficulties finding one, and of those beneficiaries looking for a new specialist, one-third had difficulties finding one.[9] The Medicare Trustees also expressed concern with the failure of Medicare to keep pace with the cost of running a practice in their 2023 report. The Trustees warned that they expect access to Medicare-participating physicians to become a significant issue in the long term.[10]

Given these unprecedented challenges and the critical importance of patient access to health care services, we encourage the committee to work with your colleagues on the Energy and Commerce Committee to pass legislation, including the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide an annual inflation-based payment update based on the MEI. This would help ensure that physicians and other health care providers can continue to provide high-quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Another challenge that must be addressed in the PFS is that of budget-neutrality, which has constrained Medicare provider payments for many years and led to arbitrary reductions in reimbursement. A budget-neutral payment system stifles physician payment and has proven to be incredibly problematic. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. At a minimum, we recommend that budget neutrality policies be revised to ensure that utilization estimates are accurate, that certain categories of services (e.g., newly covered Medicare services, health professions added, new technology, etc.) are exempt from future budget neutrality adjustments, and that the $20 million threshold that triggers budget neutrality is raised to at least $100 million. We urge you to work collaboratively with your colleagues on the Energy and Commerce Committee to address this issue that, if left unaddressed, will continue to plague the physician payment system.

[8] AAMC, The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (Jun. 2021)
[9] MedPAC, Report to Congress, Medicare Payment Policy, Chapter 4 (Mar. 2023)
[10] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Mar. 2023)

Aligning Sites of Services

Reject proposals to implement so-called site-neutral payment cuts

The AAMC continues to strongly oppose all so-called site-neutral payment cuts, as they disproportionately cut payments to teaching health systems and hospitals and disregard the real differences between hospital outpatient departments (HOPDs) and physician offices or ambulatory surgical centers (ASC). Under most proposals, teaching health systems and hospitals stand to bear a disproportionate share of these cuts. This is problematic because teaching health systems and hospitals provide complex, coordinated care to the most vulnerable patients, including Medicare beneficiaries, and as such, so-called site-neutral payment policies could significantly reduce access to high-quality care for this population.

HOPDs play an important role in rural communities by providing an elevated care setting for patients. Cuts imposed by so-called site-neutral payments may force hospitals to re-evaluate or cut service lines, or even close, which would result in reduced access to care for the patients and communities they serve. The AAMC urges the committee to look more closely at the impact of so-called site-neutral policies on rural and underserved communities.

HOPDs in teaching health systems incur higher costs of providing care, see a more complex case mix of patients, and provide an essential role in medical education. So-called site-neutral payment cuts would undoubtedly impact access to care for patients and communities and endanger teaching health systems and hospitals' ability to provide and coordinate health care services that are frequently unavailable to under-resourced patients and communities.

So-called site-neutral legislative proposals disregard the fact that the cost of care delivered in HOPDs is fundamentally different from other sites of care. 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. Expanding so-called site-neutral cuts could jeopardize access to care for Medicare beneficiaries and all patients, especially the most medically complex.

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. So-called site-neutral payment policies would plunge HOPDs into a deleterious financial position, which could result

in HOPD closures, thereby reducing access to care for Medicare beneficiaries and other patients in rural areas who require these services.

Health Care Workforce

The health care workforce in the US is in a dire state due to myriad factors including burnout, COVID-19, unprecedented violence against providers, and aging. The US is projected to face a physician shortage of up to 124,000 physicians by 2034 in both primary care and specialty care.[11] As the AAMC has discussed with you, these shortages in physician supply will have a real impact on patients, particularly those living in rural, frontier, island, or non-contiguous settings, as well as other already underserved communities. The AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need to add an additional 102,400 to 180,400 physicians immediately just to meet current demand.[12] These estimates, which are separate from the 2034 shortage projection ranges, illustrate the magnitude of current barriers to care and provide an additional reference point when gauging the inadequacy of physician workforce supply.

Addressing the nation's physician workforce shortages in both primary care and other needed specialties requires a multipronged, innovative, public-private approach beyond just increasing the overall number of physicians, including implementing team-based care models and furthering the use of technology. We are open to and in fact, ask for, innovative solutions to address health workforce shortages. Since the academic year 2002-2003, total medical school enrollment has grown by more than 38 percent, as medical schools have expanded class sizes and more than 32 new medical schools have opened. Indeed, our institutions have risen to the challenge, taking serious steps to enroll, educate, and produce more physicians. This expansion has been thoughtful, deliberate, and with significant cost – our institutions should be acknowledged and applauded. While this increase is encouraging, additional action is still needed to address the physician shortage. Though data show that students from rural areas who matriculate to medical school have a greater tendency to practice in a rural area, more must be done to support programs that lay out a pathway to medicine for students from rural areas, particularly as the number of rural students planning to attend college decreases.[13]

As mentioned earlier, physician and hospital payments certainly contribute to workforce shortages and facility closures. Providers are being expected to do more with less, with many smaller practices realizing that keeping up with administrative burden and rising costs is simply not sustainable. Teaching health systems and hospitals, in particular, incur costs that other facilities do not due to their mission-focused work, and they require tremendous resources to operate – which not all communities have. Though rural training is a key component to attracting

[11] The Complexities of Physician Supply and Demand: Projections From 2019 to 2034, Prepared for the AAMC by IHS Markit Ltd., June 2021.
[12] Ibid.
[13] Marcus J. Number of rural students planning to go to college plummets. The Hechinger Report. https://hechingerreport.org/number-of-rural-students-planning-on-going-to-college-plummets/. Published Dec. 18, 2020. Accessed Oct. 20, 2023.

and retaining physicians in rural settings, it is important to note that not all communities can sustain a teaching hospital. Faculty recruitment, limited patient volume, and adequate resources remain a challenge when operating rural teaching hospitals. This is born out in the data that show that many rural teaching hospitals remain under their Medicare graduate medical education (GME) cap.

Payment is just one of the contributing factors to rural physician shortages. Physicians and other health care workers are not always solely motivated by earnings, but also by other factors such as family, schools, environment, state or local regulations, and others. Much has been tried to recruit physicians to rural and underserved areas including loan repayment programs, increased training opportunities, and recruiting students from rural areas. However, pathway programs remain chronically underfunded, and the shifting practice environment from state to state weighs heavily on new physicians as they determine where and what to practice.

Build upon historic bipartisan progress and pass the Resident Physician Shortage Reduction Act (H.R. 2389) which would responsibly increase the number of Medicare-supported GME positions

The AAMC appreciates and applauds that Congress has taken bipartisan steps to expand Medicare support for GME to help address current and projected physician shortages. In fact, the 1,200 new positions that Congress provided in the Consolidated Appropriations Act, 2021 and the Consolidated Appropriations Act, 2023, represented the first new investment in Medicare-supported GME since 1997. The AAMC urges Congress to build upon these historic efforts and to enhance investment in Medicare-supported GME, which helps offset a portion of the costs associated with operating residency training programs. As the nation's population ages and requires more medical care, it is imperative that the physician workforce is equipped to meet the needs of patients and communities. For this reason, the AAMC urges both the committee and Congress to pass the bipartisan Resident Physician Shortage Reduction Act of 2023 (H.R. 2389), which would gradually increase the number of Medicare-supported GME positions by 2,000 per year over seven years.

Better equip rural teaching hospitals to apply for new Medicare-supported GME positions

The Consolidated Appropriations Act, 2021, Section 126 provided 1,000 new Medicare-funded Graduate Medical Education (GME) positions, the first Congressionally approved Medicare-funded positions in almost twenty-five years. The legislation authorized the CMS to distribute up to 200 positions per year to four categories of qualifying hospitals; rural hospitals or hospitals treated as rural, hospitals that are over their Medicare GME cap, institutions located in states with new medical schools or branch campuses, and hospitals that serve Health Professional Shortage Areas (HPSAs). Hospitals must demonstrate an ability to use the positions within five years of the award and hospitals must show a lack of room to expand under the hospital's current full-time equivalent (FTE) Medicare cap. CMS limited the distribution to a minimum of five FTEs a year to qualifying hospitals that apply, and prioritized the distribution of positions based on the HPSA score associated with location where at least 50 percent of resident training takes place.

A hospital that meets any of the four qualifying hospital criteria and the other application requirements is eligible for GME position distribution. CMS distribution methodology gave

preference to qualifying hospitals based on the HPSA score; those teaching hospitals with the highest HPSA score received distributions of positions first, and if any positions were left over, CMS would award slots to institutions with the next highest HPSA score. CMS repeated this process, going further down the priority list until all positions were distributed. Though relatively few geographically rural hospitals applied for positions, CMS awarded positions to at least five institutions located in rural areas. In future application cycles, greater participation by rural hospitals could mean more positions distributed to geographically rural teaching hospitals. The AAMC urges the committee to work with CMS to engage with rural teaching hospitals to ensure robust participation in future award cycles.

Provide initial resources for Rural Track Programs

The Consolidated Appropriations Act, 2021, Section 127 greatly strengthened a proven pathway for rural graduate medical education development. The legislation provided much-needed updates to rural track programs (RTPs), a policy originally introduced in the Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, BBRA). An RTP (called a rural training track program until October 1, 2022) is a partnership between an urban teaching hospital and rural training sites. When greater than fifty percent of resident training occurs at a rural site (or sites), participating urban and rural hospitals may receive additional graduate medical education reimbursement through Medicare GME positions. Though originally intended to be a catalyst for growth in rural training, the program, as introduced, was greatly limited by policies that narrowed participation in RTPs.

Three specific policy changes brought about by Section 127 increased the viability of the RTP as a catalyst for rural GME development: enabling rural hospitals to take advantage of increased cap positions, similar to their urban hospital counterparts when they participated in RTPs; removing the "separately accredited" requirement; and allowing hospitals to participate in multiple RTPs and receive additional cap positions associated with the amount of time RTP residents train in their respective institutions.

Prior to Section 127, only separately accredited programs could participate in RTPs; for many years, the only separately accredited programs were offered in family medicine. This policy had the effect of limiting urban and rural providers that had the knowledge and capacity to expand rural training to rural hospitals in adjacent communities.

As of October 1, 2022, hospitals may create an RTP in any specialty, unbound by the requirement that programs have separate accreditation. This means that hospitals may create RTPs that address the specific patient needs of the communities in which they train. Paired with the ability to create multiple RTPs, the effectiveness of this program in promoting rural training will have a lasting impact on the communities these hospitals serve.

A significant barrier to starting new rural residency programs is funding the startup costs associated with accreditation, finding and developing new faculty, and recruiting new residents. New rural residency programs and RTPs may take advantage of seed money provided through the Health Resources and Services Administration (HRSA) Rural Residency Planning and Development (RRPD) grants. RRPD grants provide substantial startup funds and technical assistance for developing new rural residency programs and RTPs. Since 2019, HRSA has

administered roughly $54 million to 73 organizations, which has led to the development of 38 newly accredited rural residency programs.[14] We urge the committee to work with your Energy and Commerce Committee colleagues (and other Congressional leaders) to increase investment in RRPD grants.

Reduce administrative burden on hospitals and physicians

The AAMC appreciates that the RFI has solicited ways to encourage "providers to spend more time on patients than paperwork." AAMC member teaching health systems and hospitals and their faculty physicians are committed to providing the best possible care for their patients, and must navigate an extraordinarily complex environment of rules, regulations, and red tape. Administrative burden contributes to worsening burnout among physicians and other clinicians, and leads providers to spend more time working through paperwork than treating patients.

Several recent congressional proposals aimed at increasing transparency stand to further burden providers. While oft well-intentioned, the AAMC urges the committee to weigh the perceived benefits of transparency with the costs to providers. For example, the committee-passed Lower Costs, More Transparency Act (H.R. 5738) would impose a national provider identifier (NPI) on all HOPDs. The AAMC believes that this policy would impose additional administrative and financial burdens on our members. Teaching health systems and hospitals 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. AAMC member teaching health systems and hospitals 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. The AAMC urges the committee to avoid burdensome measures in future legislation.

Increased utilization of prior authorization has emerged as a common way for insurers to delay or ultimately deny care to patients. Though prior authorization practices are an administrative albatross to physicians participating in insurance networks across the country, a spotlight has recently been shined on the Medicare Advantage program. Medicare Advantage beneficiaries should receive the same care and benefits as those in traditional Medicare. However, many Medicare Advantage patients must wait for pre-approval of common treatments. This extra administrative step places a significant burden on physicians and can also result in adverse effects on patient care. A study conducted by the Office of Inspector General (OIG) in the Department of Health and Human Services (HHS) showed that 75 percent of initially rejected services and procedures were overturned by Medicare Advantage when appealed by providers.[15] Having to consistently appeal these decisions only to have a majority of them overturned is inefficient and places unnecessary stress on both patients and providers. An AMA survey conducted in December 2021 found that 93 percent of physicians saw delays in care due to prior authorization and 82 percent said the delays caused by prior authorization caused patients to

[14] https://www.hrsa.gov/rural-health/grants/rural-health-research-policy/rrpd
[15] U.S. Department of Health and Human Services, Office of Inspector General, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials; Report (OEI-09-16-00410) (Sept. 2018).

forgo treatment altogether.[16, 17] Patients cannot afford these artificial delays or barriers to care, especially in rural America.

The AAMC is pleased that the committee passed the bipartisan Improving Seniors' Timely Access to Care Act (H.R. 3173), which would streamline patient care and allow faculty physicians and other providers at teaching hospitals to spend more time treating patients and training the next generation of physicians. The AAMC urges the committee to seek additional opportunities to ensure that insurers are not burdening providers with administrative hurdles that prevent patients from accessing the care that they need.

Innovative Models and Technology

Ensure the continued move to value-based care by passing the Value in Health Care Act (H.R. 5013)

The AAMC strongly supports the Value in Health Care Act (H.R. 5013). This bipartisan legislation would make needed reforms to alternative payment models (APMs) and help increase the adoption of value-based care models, which seek to link payment to quality of care as opposed to volume of services. APMs stand to create savings in the Medicare program, furthering its solvency, while also ensuring that patients have access to high-quality care. H.R. 5013 would extend the Medicare and CHIP Reauthorization Act's (MACRA, P.L. 114-10) advanced APM incentives that are scheduled to expire on Dec. 31, 2023, and also endow CMS with the authority to adjust qualifying thresholds to ensure that rural, underserved, primary care and specialty practices are not disincentivized to participate. The bill would also remove revenue-based distinctions that disadvantage rural and safety-net providers. Among other improvements, the H.R. 5013 would also establish a voluntary track for accountable care organizations (ACOs) in the Medicare Shared Savings Program to take on higher levels of risk, as well as provide technical assistance for clinicians new to APMs. The AAMC urges the committee to pass this legislation, and in particular, take action to ensure that the advanced APM incentives do not expire on Dec. 21, 2023.

Make key COVID-19 telehealth flexibilities permanent

Throughout the COVID-19 PHE, Congress authorized and CMS implemented numerous waivers and flexibilities that vastly improved patient access to care. Congress extended some of these key waivers and flexibilities until Dec. 31, 2024 through the Consolidated Appropriations Act, 2023, but without further Congressional action they will expire. To that end, the AAMC urges you to make permanent the following COVID-19-related waivers and flexibilities:

[16] American Medical Association, 2021 AMA Prior Authorization (PA) Physician Survey; (Dec. 2021).

Allow payment for telehealth services in all geographic locations, including the patient's home
During the PHE, providers were paid for telehealth services furnished by physicians and other health care providers to patients located in any geographic location and at any site, including the patient's home.

The removal of the geographic location restrictions has improved access to care, in particular in rural and underserved areas. This policy has allowed patients to remain in their homes, reducing their exposure to COVID-19 and reducing the risk of exposure to another patient or their physician. It also means that patients who find travel to an in-person appointment challenging can receive care, which may be particularly important to patients with chronic conditions or disabilities who need regular monitoring. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care.

Without Congressional action, after Dec. 31, 2024, telehealth can only be provided to patients in non-Metropolitan statistical areas (non-MSAs) located at an originating site (except for mental health services). In other words, patients in rural areas would no longer be able to receive care at home and would be required to travel to an originating site which may be a long distance from their home. Patients in medically underserved locations within metropolitan statistical areas (MSAs) will not be able to access telehealth services at all. Rural area patients should not be penalized and prevented from receiving services because of where they live.

Allow payment for audio-only telehealth services
Audio-only telehealth services are crucial to providing access to specific populations, particularly for Medicare beneficiaries who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Patients in rural and other underserved areas and those with lower socioeconomic status are more likely to have limited broadband access, making it more difficult to receive telehealth services through audio and video interactions. For these patients, their only option to receive services remotely may be through a phone. These patients should be allowed to access health services through audio-only telehealth services.

Reports suggest that lack of video services or discomfort regarding the use of video may particularly affect certain populations, some of whom have high-risk and chronic conditions, including older adults, those with low socioeconomic status, those in rural communities, and certain races and ethnicities. Data from the Clinical Practice Solutions Center (CPSC), which contains claims data from 90 physician faculty practices, shows that approximately 30 percent of telehealth services were provided using audio-only telephone technology in April and May 2020.[18] The proportion of telephone/audio-only visits increased with the age of the patient, with 17 percent of visits delivered via audio-only interaction for patients 41-60 years of age, 30 percent for patients 61-80 years of age, and 47 percent of visits for patients over 81. CMS also

[18]AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

released data showing that nearly one-third of Medicare beneficiaries received telehealth by audio-only telephone technology.[19,20] This demonstrates the importance of continuing to allow equitable coverage and payment for audio-only services to Medicare beneficiaries, and we urge the committee to take steps to make this coverage permanent.

Not only is audio-only access a health disparities issue, but covering audio-only visits is also an important recognition of the value of provider effort. Many services can be provided in a clinically appropriate way via an audio-only interaction, and patients and practitioners should be able to choose this option when clinically appropriate.

Allow physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), and audiologists to provide telehealth services

In the Consolidated Appropriations Act, 2023, Congress extended a waiver that allows PTs OTs, SLPs, and audiologists to remain as part of the definition of eligible telehealth providers, thus making them eligible to receive payment for services provided via telehealth. As we have discussed previously in this letter, addressing the workforce shortage will require a multipronged approach, including innovation in care delivery; greater use of technology; as well as improved, efficient use of all health professionals on the care team. PTs, OTs, SLPs, and audiologists have proven throughout the PHE that they are able to furnish high-quality care via telehealth effectively, safely, and efficiently to patients. Expanding the definition of eligible providers has resulted in increased access to care, making it obtainable to those who might not otherwise be able to receive these services, particularly in rural and underserved areas. Patients have come to rely on being able to obtain these services virtually. In order to ensure that this increased access to care remains, the AAMC urges the committee to take steps to make permanent this expanded definition of eligible telehealth provider.

Allow payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for telehealth services

We urge the committee to pass legislation to make permanent payments to FQHCs and RHCs for telehealth services. Until Dec. 31, 2024, Medicare can pay for telehealth services when RHCs and FQHCs serve as the distant site. RHCs and FQHCs were able to effectively furnish telehealth services and treat patients via telehealth during the PHE and should be allowed to continue to do so. If FQHCs and RHCs are no longer able to furnish telehealth services to patients when this waiver expires, this will limit access to care, particularly in rural and underserved areas which may negatively impact patient health.

[19] HHS ASPE Issue Brief: Medicare beneficiary use of telehealth visits: Early Data from the Start of the COVID-19 Pandemic (July 2020)
[20] S Verma, Health Affairs Blog: Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. (July 2020)

Allow virtual supervision of residents for telehealth and in-person services in all geographic locations

During the COVID-19 PHE, CMS allowed the supervisory requirement for teaching physicians 'to be present for the key portion of the service through real-time audio/ video technology' (herein referred to as virtual supervision) for both services when the resident and patient are together in-person (herein referred to as in-person services) and telehealth services in all residency training locations. In the calendar year 2021 PFS, CMS finalized a policy to permanently allow virtual supervision of residents in training sites located in non-metropolitan statistical areas (non-MSAs). CMS stated that this policy would improve access to care in these areas. In the CY 2024 PFS, CMS proposes to allow virtual supervision of residents furnishing telehealth services in all residency training locations through December 31, 2024.

The AAMC strongly supports CMS's 2024 PFS proposal to allow virtual supervision of residents for telehealth services in all residency training locations through December 31, 2024, as it will increase access to care, and we urge Congress to encourage CMS to make it permanent.

Residents have been virtually supervised safely and effectively during the PHE, for both in-person and telehealth services. In both instances, the teaching physician is present virtually during key and critical portions of the service rendered through interactive audio/video real-time communications technology, and both the attending physician and resident have access to the electronic health record. Teaching physicians render personal, identifiable physician services and exercise full personal control over the management of the care for which payment is sought. CMS requires that the documentation in the patient's medical record must clearly reflect how and when the teaching physician was physically present, along with a notation describing the specific portions of the service for which the teaching physician was virtually present. After the visit, if medically necessary, the teaching physician continues to engage with the patient through phone calls, messages, video updates, study reviews, and collaboration with other providers.

The use of telehealth has been of great benefit for patients, both during and after the COVID-19 PHE. Telehealth maintains and expands access to safe and effective care, particularly for patients in rural and other underserved areas, those with lower socio-economic status, those with disabilities, the elderly, and those from certain racial and ethnic backgrounds that have historically experienced limited healthcare access. Furthermore, physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, potentially reducing hospital admissions. Telehealth also protects patients and staff from exposure to infectious diseases, such as COVID-19 and the seasonal flu. Allowing residents to provide these telehealth services while being supervised virtually further expands access and promotes training opportunities.

As part of their training, it is essential for residents to have experience with providing services using telehealth, as residents will be providing services via telehealth independently in the future. Using telehealth during residency will ensure physicians are appropriately trained in this delivery modality before entering the physician workforce. Virtual supervision of residents allows the

teaching physician and residents the opportunity to provide telehealth services safely and effectively from different locations. They interact with the patient virtually, receiving real-time information from the patient simultaneously. This enables the supervising physician to take an active role in patient evaluation and treatment. Video platforms allow the resident and teaching physician to communicate seamlessly by sending real-time private messages to each other and/or by meeting virtually face-to-face in a private breakout room separated from the patient. As a result, the teaching physician and resident do not need to be in the same room to deliver synchronized patient care. The need and demand for telehealth services are expected to increase as remote digital tools for at-home health monitoring continue to expand, and the population continues to age, resulting in transportation and mobility challenges.

Virtual supervision of in-person services improves access to care by bringing more care directly where patients are and allowing teaching physicians to oversee care across multiple locations. It also offers the added advantage of having residents onsite with the patient to facilitate audio/video communication and observations for the remote teaching physician. An example of the benefits of virtual supervision of an in-person service is when a psychiatric resident is caring for patients overnight in the emergency department and evaluates a patient with the attending psychiatrist remotely supervising through a secure platform. This teaching physician can communicate directly with the patient and the resident and has access to the patient's medical record. Under such an arrangement, the attending psychiatrist would be available in the case of a psychiatric emergency to virtually supervise the resident involved in the patient's care, thereby increasing access.

Additionally, training programs have increased the practice of sending residents to medically underserved areas for rotations. For example, residents may be involved in providing care to patients through mobile treatment units and in hospital at home programs. During the COVID-19 PHE, teaching physicians and residents have demonstrated their ability to effectively provide care through virtual supervision, which improves access,[21] outcomes, and patient satisfaction[22,23] through these mobile service lines. Not allowing virtual supervision could impact training programs to the extent they will no longer be able to continue if teaching physicians were required to be physically present at mobile locations.

To continue to promote access to care, we ask the committee to work with the Energy and Commerce Committee and CMS to make permanent virtual supervision of residents in all residency training locations.

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[21] How Do Mobile Health Clinics Improve Access to Health Care? Tulane University School of Public Health and Tropical Medicine Blog (Jun. 2021).
[22] Caplan GA, et al, A meta-analysis of "hospital in home," Med J Aust. (Nov. 2012)
[23] HRSA Data on Health Professional Shortage Areas by Discipline can be found here: https://data.hrsa.gov/topics/health-workforce/shortage-areas

Remove In-Person Visit Requirements for Mental Health Services

In previous rulemaking, CMS implemented provisions in the Consolidated Appropriations Act, 2021 that removed geographic restrictions and permitted the home to be an originating site for telehealth services for the treatment of mental health disorders, as long as the practitioner furnishes an initial in-person visit 6 months prior to the first telehealth visit as well as a subsequent in-person visit at an interval to be determined by the HHS Secretary. We commend Congress for removing the geographic restrictions and originating site requirements for Mental Health Services furnished via telehealth. To further increase access to care, we urge the committee to pass legislation to remove the in-person visit requirement because it will decrease access to care.

During the PHE, the removal of Medicare's geographic and site of service limitations for services furnished via telehealth significantly increased access to care, particularly for behavioral telehealth services. In April 2020, at the height of the COVID-19 PHE, telehealth visits for psychiatry and psychology surpassed 50 percent of the total services. According to data from faculty practices included in the CPSC, the use of telehealth for mental health services remained consistent throughout 2020 and 2021.[24] And the use of telehealth services by behavioral health providers has remained high. In addition, there has also been a reduction in missed appointments for behavioral health services because telehealth expansion has made it easier for patients to access care. This is particularly important in mental health because there is a shortage of providers.

The statute requires an initial in-person visit prior to the telehealth visit, as well as a subsequent in-person visit at an interval to be determined by the Secretary; however, we believe that an in-person requirement acts as a significant barrier to care for mental health services. Continuation of care is crucial for mental health services, and this in-person visit requirement may result in a lapse of care and ultimately, negative clinical outcomes for patients. Mental health services are the only type of service provided by telehealth that would require an in-person visit at a specific interval, which is arbitrary and discriminatory against this particular type of service. Furthermore, the in-person requirement will increase wait times for those in need of an in-person visit due to workforce shortages. It also adds an additional burden of commuting to see the provider. This burden will disproportionally affect those in underserved communities or rural areas and anyone who does not have reliable transportation.

Promote the Use of Interprofessional Consults and Eliminate Barriers

The AAMC and its member health systems have found the use of provider-to-provider telehealth modalities and peer-mentored care as important ways to improve access to care, particularly for specialties like behavioral health where there are significant access and workforce challenges. However, interprofessional consults have been underutilized due to obstacles related to payment policies, some of which are summarized below.

[24] AAMC-Vizient Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a product of the AAMC and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

The AAMC has partnered with over 50 adult and pediatric health systems through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional consults ("eConsults") and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high-value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist's guidance as well as decreased out-of-pocket costs, including a specialist visit, travel, and time away from work. eConsults can be particularly beneficial for rural patients who may face challenges around access to care and long travel times to see a specialist. Payers also benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs.

However, there are several barriers to the use of Interprofessional Consults, including challenges with interoperability across systems, the code descriptors, and requirements related to coinsurance.

CMS requires that providers collect coinsurance from their patients when billing for interprofessional consults. The coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider and one for the consulting provider. While we believe that it is appropriate to reimburse both providers for their work in conducting the interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service predictably causes confusion. Additionally, interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred.

We continue to believe that the "two coinsurances" issue will stifle the use of these value-promoting, physician-to-physician services that saves costs to the Medicare program. Therefore, we ask the committee to consider where there may be pathways to waive the patient coinsurance for these important services.

<u>Increase access to remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM)</u>

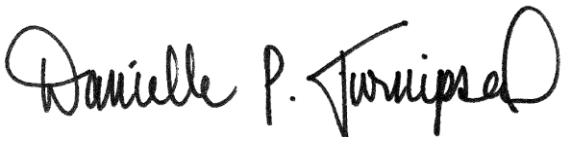
Health care providers and their patients can experience many benefits from the use of remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services including reduced readmissions, shortened hospital stays, improvements in quality of life, and lower costs. RPM involves the collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. It allows patients to be monitored remotely while in their homes, and for providers to track patients'

physiologic parameters (e.g., weight, blood pressure, glucose) and implement changes to treatment as appropriate. Physicians and practitioners may provide RPM for patients with acute and chronic conditions. Remote Therapeutic Monitoring (RTM) involves utilizing devices to monitor a patient's health or their response to treatment using non-physiological data. This practice includes collecting data related to musculoskeletal and respiratory medication or therapy responses. These services allow physicians to track their patients' health metrics without requiring multiple in-person visits from patients whose schedules cannot accommodate greater time commitments. As a result, RPM and RTM services can increase access to care, particularly in rural and underserved areas; however, there are many obstacles related to payment policies that result in underutilization of these services.

Allow Less Than 16 Days of Monitoring Within a 30-day Period for RPM and RTM Services
One of the barriers to the use of RPM and RTM services is the requirement that to bill for the initial set-up and continued monitoring, monitoring must occur during at least 16 days of a 30-day period. The 16-day requirement prevents providers from using these codes when clinical indications are that the patient would require less than 16 days of monitoring. For example, patients with pneumonia or COPD exacerbation can be sent home on oxygen therapy, requiring oxygen saturation (O2sat) monitoring. Often, pneumonia or COPD exacerbation improves within less than 16 days. We urge the committee to work with CMS to allow fewer than 16 days of data transmission by a patient in a given month to increase access to care and to encourage policies that promote the use of remote patient monitoring as appropriate.

Thank you for the opportunity to provide input on this RFI. The AAMC looks forward to continuing to work with you on ways to improve health care access to rural and underserved communities. If you have any further questions, please contact my colleague Leonard Marquez, Senior Director of Government Relations & Legislative Advocacy (lmarquez@aamc.org), or Ally Perleoni, Director of Government Relations (aperleoni@aamc.org).

Sincerely,



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