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| The Honorable Ron Wyden | The Honorable Mike Crapo |
| Chair | Ranking Member |
| Senate Finance Committee | Senate Finance Committee |
| 221 Dirksen Senate Office Building | 239 Dirksen Senate Office Building |
| Washington, DC 20510 | Washington, DC 20510 |

Dear Chair Wyden and Ranking Member Crapo:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to respond to your recently released whitepaper “Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B.” We applaud your commitment to ensuring that the Medicare program remains strong and solvent for patients and physicians and your bipartisan, thoughtful approach to this issue is commendable.

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 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 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.

Through their mission of providing the highest quality patient care, teaching physicians who work at teaching health systems and hospitals provide care in what are among the largest physician group practices in the country, often described as “faculty practice plans” because many of these physicians teach and supervise medical residents and students as part of their daily work. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Additionally, this care is often multidisciplinary, and team-based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that faculty practice plans range in size from a low of 115 individual national provider identifiers (NPIs) to a high of 3,694 NPIs, with a mean of

1,258 and a median of 1,088, meaning that they tend to be quite large.[1] These practices support the educational development of residents who will become tomorrow's physicians.

Teaching physicians are vital resources to their local and regional communities, providing significant primary care and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. Their patient base may span regions, states, and even the nation. They also treat a disproportionate share of patients for whom issues associated with social determinants of health, such as housing, nutrition, and transportation, contribute significantly to additional health challenges, adding greater complexity to their care.

**Structural Challenges within the Medicare Physician Payment System**

As currently structured, the Medicare physician payment system is on a path that jeopardizes Medicare patients' access to physicians. The Medicare Access and CHIP Reauthorization of 2015 (MACRA) established a six-year freeze on updates to physician payments from 2019 through 2025; in other words, during this period there would be no updates to Medicare payments to physicians. Beginning in 2026, the law specifies that clinicians participating in advanced APMs who also meet certain thresholds would receive an update of 0.75 percent, and those who are not in AAPMs would receive a 0.25 percent update. These updates are well below the rate of inflation. According to an American Medical Association (AMA) analysis of Medicare Trustees' data, when adjusted for inflation Medicare physician payment has been reduced by 26 percent from 2001–2023.[2] In addition to reductions in reimbursement, in recent years physicians have faced numerous challenges, including the COVID-19 pandemic and its aftermath, rising inflation, and workforce shortages.

We remain deeply concerned about the impact of these significant cuts and the minimal updates on patients in future years. In the 2024 Medicare Trustees report, the Trustees expressed concern with the failure of Medicare payments to keep up with the cost of running a practice and warned that they expect beneficiary access to Medicare-participating physicians to become a significant issue in the long term.[3] According to the Medicare Payment Advisory Commission (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.[4] Additionally, the AAMC projects that by 2036, the country could experience a shortage of between 13,500 and 86,000 physicians.[5] These shortages will be exacerbated if physicians continue to face cuts in payment, especially when coupled with continuing financial challenges facing teaching health systems and hospitals and faculty practices.

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[1] Data derived from The Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.

[2] American Medical Association, Economic and Health Policy Research, 2023 https://www.ama-assn.org/system/files/ama-medicare-gaps-chart-grassroots-insert.pdf

[3] 2024 Medicare Trustees Report: https://www.cms.gov/oact/tr/2024

[4] MedPAC, Report to Congress, Medicare Payment Policy, Chapter 4 (Mar. 2023).

[5] AAMC, The Complexities of Physician Supply and Demand: Projections From 2021-2036 (Mar. 2024) available at https://www.aamc.org/media/75231/download?attachment

The AAMC appreciates and agrees with your recognition that Congress must do something to address the ongoing structural problems with the Medicare Physician Fee Schedule (PFS). We offer the following insights in response to the whitepaper:

**Conversion Factor Fluctuations and Restraints/Addressing Payment Update Adequacy and Sustainability and Budget Neutrality Adjustments to the Conversion Factor**

The AAMC recommends that Congress ensure that any payment system provides financial stability through a baseline positive annual update that reflects inflation in practice costs and eliminates or replaces budget neutrality requirements to allow for appropriate changes in spending growth. The payment system should also recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations that would increase Part A costs). To this end, the AAMC supports the bipartisan Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would make key improvements to the PFS, including tying updates to the full Medicare Economic Index (MEI) beginning in 2025.

We believe that there are ongoing structural problems with the Medicare PFS that must be addressed. Medicare provider payments have been constrained for many years by the budget-neutral system, which has led to arbitrary reductions in reimbursement. 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 $53 million. We welcome an opportunity to work collaboratively with the Centers for Medicare and Medicaid Services (CMS), Congress, and other stakeholders to address these long-term challenges in the future.

**Incentivizing Participation in Alternative Payment Models (APMs)**

The AAMC is concerned that the end of the bonus payment will discourage participation in advanced alternative payment models (AAPMs) in the future. Value-based care is improving patient care and successfully reducing costs in the health care system. These payment system reforms have been a good investment for the Medicare program. For example, accountable care organizations (ACOs) participating in the Shared Savings Program have saved Medicare $13.3 billion in gross savings since 2012 and, according to a Department of Health and Human Services (HHS) Inspector General Study, ACO clinicians have outperformed Medicare fee-for-service (FFS) providers on 81 percent of quality measures.[6] APMs give providers tools to innovate and coordinate care, resulting in improved outcomes for beneficiaries.

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[6] Department of Health and Human Services, Office of Inspector General. *Medicare Program Shared Savings Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality*. Daniel R. Levinson, Inspector General, August 2017, OEI-02-15-00450. Available at: http://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

Under AAPMs, participating clinicians bear financial risk for the cost and quality of care. The bonus payments have been critical to clinicians in covering the investment costs of moving to new payment models and reinvesting the five percent bonus payment into practice redesign to better manage care. This includes investing in new electronic health records (EHRs), additional staff, telehealth managers, telehealth platforms, and other areas that will enable them to better manage care when they bear the financial risk. For example, ACOs have used these incentives to coordinate patient care, fund wellness programs, and pay for patient transportation and meal programs. Although these services are not typically reimbursed under the Medicare program, they have been shown to improve health outcomes.[7,8]

The AAMC is concerned that the lack of financial incentive under the Quality Performance Program for APMs for the calendar year (CY) 2027 payment will discourage participation in AAPMs in performance year 2025 and subsequent years. While there will be a higher update to the conversion factor beginning in the 2026 payment year for qualified participants (QPs) in an AAPM as compared to non-QPs, we do not believe that this higher update will be sufficient to incentivize participation. In fact, CMS projected that it might not be until after the CY 2038 payment year when the QP conversion factor will equate to the anticipated maximum positive payment adjustment under the Merit-Based Incentive Payment System (MIPS). Therefore, we urge Congress to pass the bipartisan Value in Health Care Act (H.R. 5013), which would extend the AAPM five percent bonus for an additional six years.

We remain deeply concerned about the increase to the thresholds that will occur in the 2027 payment year (2025 performance year). The increasing thresholds that must be met to be considered QPs in advanced APMs will discourage participation, thereby limiting beneficiary access to high-quality and better coordinated care. It is very difficult for APMs to increase the volume of payments received through the APM or amount of Medicare FFS patients who receive services through the APM. It is especially difficult for ACOs in rural areas and those that include specialists since primary care determines ACO assignment, which is already resulting in many multi-specialty groups removing specialists from their ACOs and risking fragmentation of care. We urge Congress to eliminate QP thresholds altogether, or, at a minimum, give CMS the authority to set thresholds in the future at a level that will incentivize participation in AAPMs.

We further encourage Congress to explore alternatives to how bonus payments are currently structured, with payments calculated on providers' entire population of Medicare FFS beneficiaries. Given the limitations that many specialists have to engage in AAPMs with thresholds determined based on their entire populations, the current system disincentivizes participation for many providers. Instead of thresholds, a system of bonus payments based only on a provider's beneficiaries actually in AAPMs would encourage more participation by specialists, be administratively easier for providers to manage, and may result in savings to the

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[7] Shier et. al., Strong Social Supports, Such as Transportation and Help for Caregivers, Can Lead to Lower Health care use and Costs, Health Affairs Vol. 32, No. 3 (March 2013).
[8] Williams et. al., Sustainable care coordination: a qualitative study of primary care provider, administrator, and insurer perspectives, BMC Health Serv Res. (February 2019).

Medicare program. These policies, if passed by Congress, would incentivize broad physician engagement with APMs and strengthen value-based care delivery in the Medicare program.

**Rethinking the Merit-Based Incentive Payment System (MIPS)**

The AAMC is concerned that MIPS remains complex and burdensome for clinicians, with little evidence that it fulfills its goal of improving quality.[9] We urge Congress to consider several improvements to MIPS. First, remove the tournament model, which only allows rewards for success to accrue through penalties from failure, and instead allow CMS to set performance thresholds that allow all clinicians to successfully meet a prospective target. Second, to resolve some of the burdens in MIPS by recognizing measures and improvement activities that inherently satisfy multiple performance categories (quality, cost, improvement, and interoperability), as well as allowing greater credit for participation in data registries. Third, to bolster requirements for CMS to provide timely and actionable data to clinicians. To date, such data has been required under MACRA, but not provided by CMS, and without it, clinicians struggle to make informed improvements to their performance.

**Ensuring the Integrity of the PFS**

The AAMC recommends that Congress urge CMS to restore a Refinement Panel to serve as the relative value appeals process. For many years, CMS had convened the Refinement Panel to hear feedback from practicing physicians and to independently recommend refinements to relative values. Having an objective, transparent, and consistently applied formal appeals process in place is important. The Refinement Panel process provides an additional mechanism (coupled with the input from the AMA/Specialty Society RVU Update Committee (RUC)) to use the expertise of physicians and other health care professionals to determine the resources utilized in providing services.

**Ensuring Beneficiaries' Continued Access to Telehealth**

The AAMC appreciates the Committee's strong support for telehealth expansion and access. We are pleased that Congress passed an initial extension of crucial telehealth waivers until Dec. 31, 2024, and we urge the Committee to make them permanent.

<u>Eliminating geographic restrictions on a beneficiary's location, including in the home, when receiving care via telehealth.</u>

The AAMC recommends that Congress permanently allow the COVID-19 flexibilities that (1) removed the geographic restriction and (2) added the home as an originating site. This allowed payment 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. These policies allow patients to remain in their homes, reducing their exposure to viruses, as well as ensuring that patients who find travel to an in-person appointment challenging can receive care. This is particularly important for patients with chronic conditions or disabilities who need

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[9] MedPAC, Report to Congress: Moving beyond the Merit-based Incentive Payment System, Chapter 15, (March 2018).

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. We strongly recommend that Congress permanently implement these policies beyond behavioral health. At a minimum, Congress should extend these policies for two years to allow for additional time to collect data and promote continuity of care.

Removing statutory "in-person" requirements that would otherwise force beneficiaries to have an in-person visit with a behavioral health provider at least once every six months in order to ensure coverage for telehealth visits.

However, we strongly recommend the removal of the in-person visit requirements including: (1) that the practitioner must furnish an initial in-person visit 6 months prior to the first telehealth and (2) that the HHS Secretary must set a reoccurring subsequent in-person visit – currently established at every 12 months.

According to data from faculty practices participating in the Clinical Practice Solutions Center (CPSC), the use of telehealth for mental health services remained a significant portion of mental health services in 2023, following the end of the COVID-19 Public Health Emergency.[10] 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.

Continuation of care is crucial for mental health services, and in-person visit requirements 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.

We strongly recommend the removal of the in-person visit requirements; at a minimum, Congress should further delay implementation of any in-person visit requirements for two years.

Permitting the use of audio-only modalities for certain telehealth services

The AAMC commends Congress for extending payment for audio-only technology through December 31, 2024, and permanently allowing payment for audio-only technology for mental health services. However, we strongly recommend that Congress permanently allow payment for audio-only services. At a minimum, Congress should extend this policy for two years to allow for additional time to collect data and promote continuity of care.

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[10] 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.

Eliminating coverage for these important audio-only services will result in inequities in access to services for specific populations. Coverage of these audio-only services is particularly important for Medicare beneficiaries who may not have access to, or may not feel comfortable with, interactive audio/video technologies. Analysis by the HHS Office of the Inspector General suggests 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 who have dually eligible status for Medicare and Medicaid, and certain races and ethnicities.[11] Researchers have also noted that audio-only services for Medicare FFS beneficiaries have only decreased from 31% to 25.4% of all telehealth visits between 2020 and 2022,[12] suggesting the critical importance of continuing to allow equitable coverage and payment for audio-only services to Medicare beneficiaries.

In addition, 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 by audio and video interactions. For these patients, their only option to receive services remotely may be through a phone. Not only is audio-only access a health disparities issue, but covering audio-only visits is 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.

Allowing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as distant site providers.
During the Covid-19 Public Health Emergency (PHE), Congress established Medicare payment for telehealth services when RHCs and FQHCs serve as the distant site provider. This enabled RHCs and FQHCs to effectively furnish telehealth services and treat patients during the PHE. Patient access to care will be limited if FQHCs and RHCs are no longer able to furnish telehealth services to patients after December 31, 2024. We encourage Congress to permanently continue payment for telehealth services furnished by FQHCs and RHCs; at a minimum, Congress should extend this policy for two years to allow for additional time to collect data and promote continuity of care.

Allowing certain non-physician, and non-practitioner providers, such as occupational therapists and physical therapists, to furnish telehealth services.
The COVID-19 pandemic has contributed to the already strained workforce shortages. Addressing the workforce shortage will require a multipronged approach, including innovation in care delivery; greater use of technology; increased Medicare support for Graduate Medical Education; and improved, efficient use of all health professionals on the care team. Physical therapists (PTs), Occupational Therapists (OTs), Speech Language Pathologists (SLPs), and

[11] HHS OIG Data Brief, Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others to Use Telehealth During the First Year of the COVID-19 Pandemic (September 2022).
[12] J. Yu, et al., Audio-Only Telehealth Use Among Traditional Medicare Beneficiaries, JAMA Research Letter (May 2024).

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 it. Patients have come to rely on being able to obtain these services virtually. If PTs, OTs, SLPs, or audiologists are no longer able to furnish telehealth services to patients after December 31, 2024, it will result in lapses in care that may negatively impact patient health. We encourage Congress to permanently expand the definition of eligible telehealth providers; at a minimum, Congress should extend this policy for two years to allow for additional time to collect data and promote continuity of care.

**Avoid Counterproductive Cuts to Teaching Health Systems and Hospitals**

It is undeniable that 2023 was a difficult year for our nation's teaching health systems and hospitals, which faced profound financial challenges stemming from historic workforce shortages, unprecedented growth in costs, and significant uncertainty as states resumed Medicaid redeterminations. According to MedPAC, hospitals' overall FFS Medicare margins dropped to a record low -11.6 percent in 2022, and this trend is expected to persist in coming years.[13] So-called "site-neutral" payment policies have recently been proposed as a savings mechanism or offset for legislation. The policies are inherently counterproductive in that they would only further exacerbate these challenges by cutting Medicare reimbursement for care delivered in hospital outpatient departments (HOPDs). The AAMC strenuously opposes these policies, which disregard the real differences between teaching health systems and hospitals' HOPDs and other sites of care, including physician offices and ambulatory surgical centers. As we have emphasized to policymakers, teaching health systems and hospitals' HOPDs care for a more clinically and socially complex patient population than physician offices, while complying with greater licensing, accreditation, and regulatory requirements. Furthermore, HOPDs do not choose which patients come through their doors – even if a patient could be treated at a lower cost facility, HOPDs continue to treat the patients who come to them. Because of these factors, the cost of providing care in an HOPD is fundamentally different from other settings. Enacting this HOPD policy ignores these important distinctions and would result in cuts to Medicare reimbursement for drug administration services in off-campus HOPDs.

Proposed HOPD cuts, and in particular, those passed by the House of Representatives in the Lower Costs, More Transparency Act (H.R. 5378), would disproportionately impact AAMC-member teaching health systems and hospitals, many of which are safety-net providers that care for the nation's sickest and under resourced patients, including in the outpatient setting. Although our members comprise just five percent of all U.S. hospitals, they would shoulder nearly half of the cuts included under the House-passed policy. Given teaching health systems and hospitals' critical role in caring for Medicare's most vulnerable and complex beneficiaries, these proposed cuts would necessarily limit these patients' access to life-saving care and cutting-edge treatments. The negative impacts of these cuts would be felt most acutely in rural and other medically underserved communities.

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[13] https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf

Now more than ever, Congress cannot abandon our nation's teaching health systems and hospitals. Although significant investments are needed to provide relief to physicians under the PFS, the AAMC opposes financing these provisions through cuts elsewhere in the Medicare program. Teaching health systems and hospitals cannot absorb additional cuts, as it is counterproductive to sustaining their missions of patient care, education, research, and community collaborations. We implore you to avoid the seriously detrimental effect on teaching health systems and hospitals and avert endangering access to care for the patients and communities they serve.

Thank you for the opportunity to share the AAMC's thoughts on your proposal to stabilize the Medicare physician payment system. We look forward to continuing to work with you on this and other clinical and patient care issues. If you have any further questions, please contact my colleague Ally Perleoni, Director of Government Relations (aperleoni@aamc.org).

Sincerely,

Danielle Turnipseed, JD, MHSA, MPP
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CC:

David Skorton, MD
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