Response of the
American College of Physicians
to the U.S. House Ways and Means Committee
on
Addressing Chronic Disparities in Access to Health Care in Rural and Underserved Communities
October 5, 2023

The American College of Physicians (ACP) is pleased to provide comments to the House Ways and Means Committee on its Request for Information (RFI) regarding chronic disparities in access to healthcare in rural and underserved communities. We commend Chairman Smith and Ranking Member Neal in requesting this information which seeks input in five areas: payment disparities between different geographic areas; long-term financial health of clinicians and facilities; payments for identical care provided in varying sites of service; bringing new professionals into the health care workforce; and innovative care models and technology to improve patient outcomes. We are pleased to provide comments to the RFI in areas where we have policy for improving healthcare access and services to those in rural and underserved communities. Overall, reform to the Medicare payment system is vitally needed. In addition, immediate action is needed to address the existing and growing physician workforce shortage through expansion of federal programs and federal student loan incentives.

ACP is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

PAYMENT AND TELEHEALTH REFORM AS CATALYST TO INCREASING PHYSICIAN WORKFORCE

The Committee is requesting comments on policies that support the long-term health of medical professionals and facilities to ensure access to care for patients in rural and underserved areas. This includes improvements needed to Medicare payment systems and structure to incentivize clinicians to operate in rural and underserved areas.

Payment Reforms Needed to Ensure Stable Access to Quality Healthcare

As the committee likely knows, the Centers for Medicare and Medicaid Services (CMS) estimates that 61 million Americans like in rural, tribal, and geographically isolated communities across the United States, with approximately 12 percent of physicians practicing in rural communities, and 61 percent of

areas deemed health professional shortage areas (HPSA) by the federal government are located in rural areas. In this context, it is important to recognize that physicians and health care facilities who may care for a lower patient volume, have a patient population with a high rate of Medicaid and Medicare, or both. Individuals living in rural areas under age 65 are less likely to have private insurance coverage and are more likely to be uninsured than residents of other areas.[1] Almost a quarter of individuals under age 65 who live in rural areas are covered by Medicaid, as well as 22 percent of people dually enrolled in Medicaid and Medicare.[2]

It is well established that federal payment policies can increase patient access to care in rural and other underserved communities. To mitigate lower payment rates and a more limited patient, a number of policies and programs have been implemented to support rural hospitals, skilled nursing facilities, and other healthcare facilities. However, comparable efforts to help physician practices maintain viability have been more limited. Just like a critical access hospital or nursing facility, a medical practice needs to be able to cover practice expenses, including staff salaries, and provide clinicians with reasonable compensation for patient care.

Medicare Economic Index (MEI) Updates

The Medicare Access and CHIP Reauthorization Act (MACRA) must be viewed within the broader context of the physician payment system. While physician services represent a very modest portion of the overall growth in health care costs, they are primary targets for cuts when policymakers seek to tackle spending. For years physicians have struggled with a broken Medicare payment system that does not allow them to keep up with practice expenses and rising inflation. According to a recent Medicare Trustees' Report, when adjusted for inflation, Medicare payments to physicians declined by 22 percent from 2001 to 2021. That has made it much harder for physician practices to manage sharp increases in practice expenses, staffing and supply shortages.

The modest statutory updates included in MACRA have ended, and physicians are in a six-year period with no updates. The result is real reductions to payments due to inflation and budget neutrality requirements. ACP urges Congress to pass H.R. 2474, the *Strengthening Medicare for Patients and Providers Act,* to provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index. It would allow physicians to make needed investments in their practice to help ensure that they are able to deliver high quality care to their patients.

G2211 Code Implementation

ACP also urges Congress to support the full implementation of a Medicare add-on code, known as G2211, in 2024. This code will improve Medicare beneficiaries' access to high-quality, continuous care and help sustain the physician practices beneficiaries rely on for comprehensive health care. G2211 would be billed alongside codes for office/outpatient evaluation and management (E/M) visits to better account for the unique and inherent complexity of services provided through longitudinal

patient care that is based on a clinician's ongoing relationship with a patient and is related to a patient's single, serious condition or a complex condition. CMS finalized the G2211 add-on code in the calendar year (CY) 2021 Medicare Physician Fee Schedule (MPFS) final rule. However, Congress delayed the implementation of the code until 2024 to help offset Medicare funding intended to blunt the financial impact of the COVID-19 pandemic. Congress should now support the G2211 code effective January 1, 2024, which would help sustain primary care practices in rural areas.

Expansion of Pandemic Telehealth Flexibilities

ACP supports H.R. 4189, the *CONNECT for Health Act of 2023*, to extend payment-parity for audio-only health services for clinically appropriate appointments and waive permanently certain geographic restrictions on telehealth services and expand originating sites to include the home and other sites. ACP supports the expanded role of telehealth as a method of health care delivery in rural and underserved areas. Telehealth can be most efficient and beneficial between a patient and physician with an established, ongoing relationship and can serve as a reasonable alternative for patients who lack regular access to relevant medical expertise in their geographic area.

ACP also supports H.R. 3440/S. 1636, the *Protecting Rural Telehealth Access Act.* That legislation would lift geographic site restrictions for telehealth services on a permanent basis. It would also ensure that audio-only telehealth for evaluation and management services would continue at least five years after the enactment of this legislation. The bill specifies that after five years, the Secretary of Health and Human Services shall conduct a review of the furnishing of specified telehealth services through audio-only technology. Such review shall include an analysis of the impact of the roll out of broadband technology and whether the use of audio only technology is necessary to ensure access to such telehealth services.

MACRA Reform Hearings

ACP urges the Committee to convene one or more hearings on the implementation of physician payment policies within the MACRA, which sought to end the antiquated, burdensome and misaligned sustainable growth rate (SGR) payment formula, requiring annual Congressional fixes. We request these hearings to focus upon whether the current system achieves the Congressional intent to move towards value- based care and to consider the long-term viability of the current Medicare physician payment system.

We believe now is the time for consideration of MACRA reform. These hearings should focus on the characteristics of a rational Medicare payment system. This should include:

- Positive consistent and stable annual payment updates that offer the financial stability needed for our physicians to transition their practices to value-based payment models;

- Meaningful and actionable quality reporting initiatives that adequately measure the quality of care our physicians provide to their patients;
- A sufficient number of Advanced APMs for our physicians to join to provide high quality value-based care to their patients.

We urge you to provide the necessary oversight and develop reforms to ensure that MACRA achieves these goals as intended by Congress.

REVITALIZING THE HEALTHCARE WORKFORCE

The Committee is requesting comments on policies to revitalize the health care workforce across the country to improve patient access to care, especially in rural and underserved areas. This includes policies that develop new clinicians and specialties in areas of the country where shortages are most acute, encourage clinicians to spend more time on patient care than paperwork, and ensure independent practice remains a viable option in a highly consolidated health marketplace. ACP supports federal programs and student loan incentives to address workforce shortages in rural and underserved areas. Immediate action is needed to address the existing and growing physician workforce shortage through expansion of federal programs such as Medicare supported graduate medical education (GME), the National Health Service Corps (NHSC) and Community Health Centers (CHCs).

Support Funding for Federal Programs that Provide for Healthy Population

ACP supports increased funding for the NHSC, CHCs and Teaching Health Centers Graduate Medical Education (THCGME) programs. We appreciate H.R. 5378, the *Lower Costs, More Transparency Act*, reauthorizing and increasing funding for these programs. This legislation should serve as the floor for funding of these programs through fiscal years 2024 to 2029.

The NHSC awards scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of underserved communities across the country. In FY2023, with a projected field strength of 20,000 clinicians including over 2,600 physicians, NHSC members are providing culturally competent care to a target of over 15 million patients at over 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These funds will help maintain NHSC's field strength helping to address the health professionals' workforce shortage and growing maldistribution.

ACP strongly supports Community Health Centers and has continuously advocated that Congress reauthorize the program's mandatory funding as well as include robust funding in annual appropriations bills. Congress should provide sufficient and continuing financial support for these essential public health facilities that serve underserved populations that otherwise lack the financial

means to pay for their health care. For the reauthorization of the CHC program for FY2024 and beyond, Congress should continue its investment and increase funding for CHCs.

We also support expansion of the Medicare Graduate Medical Education (GME) program. ACP was greatly encouraged that bipartisan Congressional leaders worked together to provide 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act (CAA), 2021, H.R. 133, the first increase of its kind in nearly 25 years, and that some of those new slots have been prioritized for hospitals that serve Health Professional Shortage Areas (HPSAs). We encourage Congress to now pass H.R. 2389/S. 1302, the *Resident Physician Shortage Reduction Act of 2023,* which authorizes 2,000 new GME positions per year for seven years. With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over $15 billion annually), with most of the support coming from Medicare.

Increasing the Primary Care Physician Workforce Leads to a Healthier Population

Evidence clearly shows that increasing the number of primary care physicians (PCPs) helps reduce mortality. A recent study appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy. People living in counties with only one PCP per 3,500 persons have a life expectancy almost a year less than those individuals living in counties above that level. To reach the one PCP per 3,500 persons ratio in those counties (the Health Resources and Services Administration's (HRSA) threshold of a HPSA) would require an additional 17,651 PCPs, about 15 more physicians per county. To reach a more optimal one PCP per 1,500 people ratio as recommended by the Negotiated Rulemaking Committee convened by HRSA in 2010 would require 95,754 more PCPs or about 36 additional physicians in each of these counties.

Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care. ACP encourages efforts by federal and state governments, relevant training programs and continuing education providers to ensure an adequate workforce to provide primary care to patients and those continuing to be affected by the pandemic. Funding should be maintained and increased for programs and initiatives that increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.

Even before the COVID-19pandemic, the Association of American Medical Colleges (AAMC), estimated that there would be a shortage of 17,800 to 48,000 primary care physicians by 2034. A report by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase

our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience). Now, with the closure of many physician practices and physicians nearing retirement not returning to the workforce after the COVID-19 pandemic, it is even more imperative to assist those clinicians serving on the frontlines and increase the number of future physicians in the pipeline.

Remove Student Debt as a Barrier to Patient Care

ACP is greatly concerned by the already high and ever-increasing cost of obtaining a medical education and the effect those expenses have on the number of medical students and residents opting to enter careers in primary care. For example, residents played a critical role in responding to the pandemic crisis and continue to furnish care all the while many of them carry an average debt of over $200,000.

To help address the physician debt and shortage crisis, Congress should pass H.R. 1202/S. 704, the *Resident Education Deferred Interest Act*, (REDI) and H.R. 4942/S. 665, *Conrad State 30 and Physician Access Reauthorization Act.* The REDI Act allows borrowers in medical or dental internships or residency programs to defer student loan payments until the completion of their programs. The Conrad 30 program allows international doctors to remain in the U.S. upon completing their residency under the condition that they practice in areas experiencing doctor shortages. This program has brought nearly 20,000 physicians to underserved areas, filling a critical need for quality health care in our rural communities.

Reducing Administrative Burden

The Committee seeks comments on ways clinicians can spend more time on patient care than paperwork. Administrative requirements force physicians to divert time and focus away from patient care and can prevent patients from receiving timely and appropriate treatment. They are also a financial burden and contribute significantly to the burnout epidemic among physicians. A 2022 survey of more than 500 doctors from group practices found that 89 percent believe that regulatory burdens increased in the past year, and 82 percent responded that the prior authorization process in particular is very or extremely burdensome.

ACP recommends three ways Congress can help reduce administrative burden for patients and their physicians. Congress should:

- Support Section 301 of H.R. 4822, the *Health Care Price Transparency Act*. The provision includes the *Improving Seniors' Timely Access to Care Act*, which would require that Medicare Advantage (MA) plans establish an electronic prior authorization process to make it easier for physicians to determine if a prescribed procedure, service, or medication is covered. ACP also supports streamlining prior authorization for other group health plans.

- Support H.R. 2630/S. 652, the *Safe Step Act of 2023*, a bipartisan bill that would ensure patient access to appropriate treatments based on clinical decision-making and medical necessity rather than arbitrary step therapy protocols. The bill would require group health plans to provide a transparent exception process for any medication step therapy protocol.
- Support legislation that facilitates electronic health record (EHR) standardization and the adoption of new standards in medical practices that would reduce burdensome administrative tasks.

Protecting Viable Primary Care Practices During Consolidation

The Committee seeks comments on ways to ensure independent practices remain a viable option in a highly consolidated health marketplace. Research is needed to better understand the effect of private equity investment in health care. ACP recommends longitudinal research on the effect of private equity investment on physicians' clinical decision making, health care prices, access and patient care, including the characteristics of models that may have adverse or positive effects on the quality and cost of care and the patient–physician relationship. We believe passage of H.R. 5378, *Lower Costs, More Transparency Act*, is a good start at examining the effects of consolidation on independent practices. While the bill does not include private equity, it does require the Department of Health and Human Services to collect data on how its regulations affect consolidation.

ACP supports transparency regarding corporate and private equity investment in the health care industry. Policymakers, stakeholders and regulators should provide oversight of private equity activity to prevent practices like unwarranted self-referral, overreliance on nonphysician health care professionals, or consolidation that results in uncompetitive markets. While greater transparency and data collection of vertical integration activity is an important first step, ACP recommends that lawmakers and regulators scrutinize in advance and regularly evaluate after approval all mergers, acquisitions, and buyouts involving health care entities, including insurers, pharmacy chains, large physician groups, and hospitals.

ALIGNING SITES OF SERVICE

The Committee is requesting comments on policies to lower patient costs for patients by equalizing payments for identical care provided at different settings of care. Moreover, how should Congress approach equalized payment policies that lower costs while preserving access to care and discouraging health care consolidation.

ACP believes that site neutrality is good policy for Medicare, Medicare beneficiaries, and the health care system as a whole. Historically, Medicare has typically paid a higher rate for the same service when performed at a hospital outpatient department (HOPD) rather than a physician's office. Site of

service payment differentials create an incentive for hospitals to acquire physicians' practices and rebrand them as HOPDs, causing the magnitude of this problem to grow over time.

While site of-service payment differentials are not the only factor driving hospitals to acquire physician practices, they likely do play a major role. Embracing a policy of site-neutral payments could thus save Medicare considerable dollars. We do not believe that care delivered in a HOPD should be paid a higher rate when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's High-Value Care initiative, ACP supports delivery of care in the most efficient setting, while maintaining quality of care. Additionally, any changes must not negatively affect Safety-Net organizations, deny or restrict coverage of care provided by qualified and approved clinicians, or jeopardize access to primary and preventive care for millions of Americans who rely on our Nation's already stretched health care safety net. Coverage decisions should be based solely on medical evidence, best practices, and qualifications. Provider-based billing should not be used as a mechanism for hospitals to recoup/stabilize funding or as a means of ensuring access to care. Ensuring adequate hospital funding and patients' access to care can better be addressed and supported through other means, such as increased/improved health insurance coverage, strengthened workforce policies, and delivery system reforms.

INNOVATIVE MODELS AND TECHNOLOGY

The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas.

First, Congress should provide resources and support to CMS in the development of APMs. It should extend the five percent bonus for physician participation in advanced APMs. ACP urges Congress to pass H.R. 5013, the *Value in Health Care Act of 2023*, to extend MACRA's five percent advanced APM incentives that are scheduled to expire at the end of the year. That bill also gives CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs. The bill removes revenue-based distinctions that disadvantage rural and safety net providers, which is critical to improving access to care and improving health equity. This bipartisan legislation makes several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries.

Second, few APMs are available to physicians. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) mandated by the Medicare Access and CHIP Reauthorization Act of 2015, recommends new physician-focused payment models to the Secretary of Health and Human Services (HHS) for possible implementation within the Quality Payment Program. However, while some components of the recommended models have been implemented within CMS models, to date, HHS has not adopted any of the committee's suggested models.

Third, despite the lack of APMs, we support the "Making Care Primary Model" being implemented through the Centers for Medicare and Medicaid Innovation (CMMI) in eight states. This model for primary care is structured to facilitate and promote care coordination between primary care physicians and other specialists. The model aligns with recommendations in ACP's paper, "Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration."

The Making Care Primary Model is designed to provide primary care clinicians with enhanced payments, tools, and support to improve the health outcomes of their patients. It incorporates key elements that ACP proposed in the Medical Home Neighborhood Model. That model will provide a great number of opportunities for subspecialists and other specialists to more effectively coordinate care with their internal medicine colleagues and other physicians providing primary care, which will open up access and allow those specialists to see more urgent cases sooner. The model encourages more meaningful engagement between primary care specialists and other specialists. The aim is to address concerns by specialists about referrals that are sometimes inappropriate or misdirected. One of the key components of our recommended model is the prescreening of patients by the internal medicine subspecialists and other specialists as to whether or not they believe the referral is appropriate.

Conclusion

We commend you for working in a bipartisan fashion to identify solutions to the health care workforce shortage that will increase the number of primary care physicians and services being offered in rural and underserved areas. Thank you for working to ensure that the nation's health care workforce needs are met. If you have any further questions or if you need additional information from ACP, please contact George Lyons at (202) 261-4531 or glyons@acponline.org.

[1] Medicaid and Rural Health, Medicaid and CHIP Payment and Access Commission, April 2021. https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf
[2] Medicaid and Rural Health, Medicaid and CHIP Payment and Access Commission, April 2021. https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf