American College of Physicians
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Statement from the American College of Physicians
Senate Finance Subcommittee on Fiscal Responsibility and Economic Growth
The Hospital Insurance Trust Fund and the Future of Medicare Financing
February 2, 2022

The American College of Physicians (ACP) is pleased to provide our statement to the Senate Finance Subcommittee on Fiscal Responsibility and Economic Growth concerning The Hospital Insurance Trust Fund and the Future of Medicare Financing. We thank Senator Warren and Senator Cassidy for hosting this hearing to examine policies to ensure the fiscal solvency and long term sustainability of Medicare that provides insurance coverage for 60 million seniors and younger people with disabilities. Our statement will provide this subcommittee with our recommendations to enhance the value of care in Medicare through policies that would improve the Medicare Physician Fee Schedule (MPFS), reform the Medicare Access and CHIP Reauthorization Act (MACRA), enhance chronic care, strengthen Graduate Medical Education (GME), expand access to care through telehealth, and lower the cost of prescription drugs.

The American College of Physicians 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 (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

In order to improve the fiscal solvency and sustainability of Medicare it is essential that the Senate Finance Committee conducts a review of the program to determine how well its coverage, payment, and delivery systems are working to ensure that Medicare can provide our seniors with a quality, affordable care that delivers the best possible outcomes for patients. The United States spends more on health care than other industrialized countries but has lower rates of insurance coverage and produces variable and uneven health outcomes. The fee-for-service (FFS) payment system bases reimbursement for physicians and other clinicians on the number of appointments, tests, or procedures rendered rather than the quality or appropriateness of those services, contributing to suboptimal outcomes. Beyond being wasteful, unnecessary services can harm the patient. It is clear that we can do better and we urge the Committee to adopt the following reforms to improve the quality and value of care provided in Medicare.

Medicare Physician Payment Reform

We are grateful that over the last several years, the Centers for Medicare and Medicaid Services (CMS) and Congress have recognized the value of care that internal medicine and primary care physicians provide to patients. CMS approved a 2021 Medicare Physician Fee Schedule (MPFS) Final Rule that provided a significant increase in the long-undervalued Evaluation and Management (E/M) services (office-based visits) that represent a significant portion of the care that internists and other primary care physicians provide to their patients. These overdue payment increases for E/M services in the 2021 MPFS are essential to recognizing the value of primary and comprehensive care, have been many years in the making, were developed with the input and support of all physician specialties, and are imperative to support our members and their patients.

The 2021 PFS rule would have imposed a substantial budget neutral adjustment—leading to an overall reduction in the conversion factor. The net result of this is that physicians providing undervalued E/M services were going to see their payment improvements tempered somewhat by the reduced conversion factor, while others who do not bill for E/M were facing significant reductions in payment for other services in Medicare. ACP was pleased that at the end of 2020 Congress passed legislation, H.R. 133, the Consolidated Appropriations Act of 2021, that included a provision providing for a temporary 3.75 percent increase to ALL services. We also appreciate that in 2021 Congress approved legislation, S. 610, the Protecting Medicare and American Farmers from Sequester Act that provided a 3 percent increase to all services in the fee schedule. These bills have helped to mitigate a substantial portion of the cuts that were expected from budget neutrality while ensuring that the increased payments to frontline primary and comprehensive care physicians were maintained.

We believe that the federal government should provide immediate, sufficient, and sustained increases in Medicare fee-for-service payments for services provided by primary care physicians by raising absolute and relative compensation of general internists and other primary care physicians to maintain their practice viability in a manner that is not limited by the current budget neutrality constraints. **While the CY22 cuts have been deferred by the Protecting Medicare and American Farmers from Sequester Cuts Act (2021), piecemeal legislation will not adequately serve to address the systemic issues presented by the MPFS and the budget neutrality provision.**

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." The report urges the need to reform a Medicare physician payment system that not only undervalues primary and cognitive care but also does not adequately incentivize the type of quality, value-based care that patients need. The Medicare fee-for-service (FFS) payment system bases reimbursement for physicians and other clinicians on the number of appointments, tests, or procedures rendered (i.e., volume) rather than the quality or appropriateness of those services, contributing to suboptimal outcomes (i.e., value). Despite these challenges, and the need to do more to address them, ACP

appreciates recent policies enacted by Congress and implemented by CMS to strengthen internal medicine by increasing payment under Medicare for office-based E/M services.

Prevent Medicare Sequestration Cuts

Although this hearing examines the long-term outlook for Medicare, Congress needs to address an issue in the short-term also since one of the Medicare cuts addressed in the *Protecting Medicare and American Farmers from Sequester Cuts Act* is a three-month delay of the 2 percent Medicare sequester payment reductions (Jan. 1 to March 31) and a three-month, 1 percent reduction in Medicare sequester payment reductions (April 1 to June 30). We urge the Senate to extend the full moratorium on the sequester cuts at least until the end of 2022.

All too often, physician payments are the targets for federal budget trimming and ways to pay for federal spending. Physician payments have also failed to keep up with the rate of inflation over the past 2 decades. Congress should prevent the cuts that would be imposed by sequestration to ensure that internal medicine physicians who have suffered significant financial, well-being, and health challenges imposed by the pandemic are able to keep their practices open to care for Medicare patients.

Improve the Medicare Access and Chip Reauthorization Act

In April of 2015, landmark legislation was signed into law that fundamentally restructured the Medicare physician payment system. The Medicare Access and CHIP Reauthorization Act (MACRA) instituted new policies under a new payment system called the Quality Payment Program (QPP) that rewards physicians based on the quality and value of services provided. Physicians participate in the QPP under one of two payment tracks: the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs).

Last year, we joined other physician organizations to submit a joint letter to the Senate Finance Committee to **"respectfully request that the Senate Finance Committee convene one or more hearings on the implementation of physician payment policies within the MACRA, specifically focused on whether the current system achieves the Congressional intent to move towards value-based care. We also urge the Committee to consider the long-term viability of the current Medicare physician payment system."** The committee last convened a hearing to examine the MACRA program in 2016 so we believe that now would be an appropriate time to examine if it has achieved the objectives of moving our health care system to one that incentivizes the quality and value of care that physicians provide to patients.

Merit-based Incentive Payment System

Most physicians participate in the Quality Payment Program (QPP) through the Merit Based Incentive Payment System (MIPS) track, which builds on traditional fee-for-service payments by adjusting them based on a physician's performance. The MIPS program measures physicians' performance based on a scoring structure that requires physicians to report performance data to CMS in 4 weighted categories: Quality Measurement, Improvement Activities, Promoting Interoperability and Cost. Physicians receive a score based on how well they perform in each of these categories, which then determines their Medicare payment.

The Merit-Based Incentive Payment System (MIPS) component of CMS' Quality Payment Program is starting to demonstrate some forward progress for primary care physicians. CMS has been looking to evolve the MIPS program through a new pathway entitled MIPS Value Pathways (MVPs). MVPs are intended to streamline MIPS participation by allowing physician practices to report on more focused sets of measures and activities that are potentially more meaningful to their practice, specialty, or public health priority. As detailed in our comments on the 2022 Physician Fee Schedule Final Rule, CMS finalized seven MVPs to be initiated in 2023. ACP believes that the MVP pathway could be a step in the right direction if the measures included are methodologically sound and evidence-based, addressing clinical areas of importance. It is also critically important that MVPs move toward a wholescale departure from traditional MIPS in order to offer a true onramp for practices to Alternative Payment Models. In February 2020, ACP provided the original version of the Optimizing Chronic Disease Management MVP. Although ACP is pleased that CMS finalized a revised version of this MVP in the 2022 Rule, ACP believes that in order to truly reinvent MVPs, **CMS must be provided the authority to create synergy across the four performance categories. In order for this to occur, Congress likely needs to make adjustments to the MACRA statute--changes along these lines need to be carefully considered and then moved forward expeditiously.** CMS should then lead the charge in this development rather than relying on individual stakeholders to do so.

Alternative Payment Models

This pandemic has highlighted the need for physicians to transition their practice away from the traditional fee for service model to Advanced Alternative Payment Models (APMs) that promote value-based care and provide rapidly expanded capabilities, such as care management, call centers, remote monitoring and telehealth, to meet the shifting care needs resulting from COVID-19. In addition to any model specific payments, clinicians who participate in Advanced APMs in a substantial way, can earn a 5 percent Medicare bonus through 2024 if they meet certain thresholds of patients or payment through their work in this model. **We urge Congress to extend the 5 percent bonus that physicians receive if they meet performance expectations in advanced APMs for an additional six years until 2028.**

We appreciate that Congress passed legislation in 2020, H.R. 133 the Consolidated Appropriations Act of 2021 that will maintain the current patient and payment thresholds for physician participation in an Advanced APM through 2024. This legislation maintains the current threshold of 50 percent of all physician payments received through the APM and 35 percent of all patients who receive care through an APM.

ACP urges Congress to enact legislation that would modify the QP thresholds to ensure those participating in Advanced APMs can continue to earn Advanced APM incentives. Specifically, we urge Congress to pass legislation that would allow the Secretary to increase the threshold by no more than 5 percent each performance year beginning in performance year 2023 to allow for a more gradual and predictable increase.

Patient-Centered Medical Homes

These have been implemented across public and private payers, typically tied to a hybrid capitated payment approach. Payment approaches vary, but typically include a prospective per patient, per month fee; ongoing FFS payments; and retrospective payment adjustments based on performance. In some cases, the Patient Centered Medical Home (PCMH) model's generated savings struggle to exceed model payments, particularly in initial years of implementation, as was the case with Medicare's Comprehensive Primary Care Initiative and its successor, the Comprehensive Primary Care Plus program. Yet, there is some evidence that the PCMH model is associated with meaningful improvements in chronic disease management and can be a critical component of other care models, such as ACOs. The PCMH model also demonstrates promise in improving patient outcomes and physician satisfaction, reducing disparities, and recognizing the value of primary care services. For these reasons, ACP supports expansion of the PCMH model.

Improve Care for Patients with Chronic Conditions

The care of patients with multiple chronic illnesses accounts for a large percentage of Medicare spending and will continue to grow unless policies are enacted to improve the care for these illnesses. We appreciate the bipartisan effort of the Senate Finance Committee to approve the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act that was signed into law and removed some barriers to care for seniors with multiple chronic conditions. However, additional challenges remain. ACP signed onto a joint letter supporting proposals to eliminate the patient cost-sharing associated with chronic care management across public and private insurance. Evidence-based, patient-centered solutions must enable people living with serious chronic conditions to have affordable access to needed care throughout the year. Waiving cost-sharing requirements would increase coordination of care for those patients with the greatest health care needs. Research shows that the increased use of high deductible health plans (HDHPs) is associated with delays in care, testing, and treatment that can lead to avoidable disease progression.

ACP urges passage of the following legislation to expand access to chronic care services:

- **H.R. 3563, the *Chronic Disease Management Act,* which will allow HDHPs to provide patients with access to certain chronic care services and treatments with no cost sharing before meeting their deductible.**

We also urge the passage of legislation that would eliminate beneficiary co-pays for Chronic Care Management (CCM) Services. The Centers for Medicare and Medicaid Services (CMS) now pays for non-face-to-face chronic CCM services for Medicare beneficiaries who have multiple (2 or more) chronic conditions, an effort championed by ACP. However, beneficiaries are responsible for copayments on these services, which can cause undue strain on a doctor-patient relationship because patients are not accustomed to paying for a service when they do not see the doctor face-to-face. It is often difficult to convince patients that their copayment is worth the service. This co-pay should be eliminated by treating CCM services under the preventive services category under Medicare Part B to eliminate any beneficiary cost-sharing associated with the services.

Expand Primary Care Workforce through Graduate Medical Education

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 graduate medical education (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.

According to the Association of American Medical Colleges (AAMC), before the Coronavirus crisis, estimates were that there would be a shortage of 21,400 to 55,200 primary care physicians by 2033. Now, with the closure of many physician practices and near-retirement physicians not returning to the workforce due to COVID-19, it is even more imperative to assist those clinicians serving on the frontlines.

We are pleased at the end of 2020, bipartisan congressional leaders worked together to provide 1,000 new Medicare supported GME positions in the Consolidated Appropriations Act, 2021, H.R. 133, an action supported by ACP. This was the first increase of its kind in nearly 25 years. The new slots must be distributed with at least 10 percent of the slots to the following categories of hospitals: hospitals in rural areas; hospitals training over their GME cap; hospitals in states with new medical schools or new branch campuses; and hospitals that serve areas designated as health professional shortage areas (HPSAs).

We urge the Senate to approve the Resident Physician Reduction Shortage Act of 2021 (H.R. 2256/S. 834), reflects the 1,000 new GME slots added by H.R. 133, and would create 14,000 new GME positions over seven years and use the same distribution categories as specified in H.R. 133 in 2020.

We also urge the Senate to support provisions in the Build Back Better Act (BBBA) that was passed by the House that would create a new Pathway to Training Program to provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical schools. A student would be required to practice a year in a medically underserved area after residency for each year they receive a scholarship. ACP is pleased that an additional 4,000 Medicare-supported GME slots have been included in the House-passed BBBA in Sec. 137405 pertaining to the Pathways to Practice Training Program. A thousand slots associated with the Pathways to Practice Training Program can be found in Sec. 137404.

As the Finance Committee considers policies concerning GME, we recommend reforms to this program to expand additional residencies slots for primary care physicians. Expanding the primary care workforce can improve the quality of health care and lower costs. Studies show that increasing one primary care physician per 10,000 people in one state was associated with a rise in that state's quality rank by more than 10 places and a reduction in overall spending by $684 per Medicare beneficiary. Another study showed that adding one primary care physician per 10,000 people in the United States resulted in a 6 percent decrease in all-cause mortality, which amounts to approximately 114,520 fewer people dying in the United States each year.

Improve Access to Care through Telehealth

Studies have already shown the benefits of the use of telehealth, which has risen sharply since the pandemic. According to the Department of Health and Human Service's December 2021 report on telehealth use, the number of Medicare fee-for-service beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020. A recent study by the Centers for Disease Control and Prevention (CDC) concerning the use of telehealth in health centers, suggested that "telehealth can facilitate access to care, reduce risk for transmission of SARS-CoV-2, conserve scarce medical supplies, and reduce strain on health care capacity and facilities while supporting continuity of care." An article published by the Commonwealth Fund, notes that "tele- mental health has a robust evidence base and numerous studies have demonstrated its effectiveness across a range of modalities (e.g. telephone, videoconference) and mental health concerns (depression, substance use disorders)."

Expand the Extension of Telehealth Services Through the 1135 Waiver Authority

In 2020, CMS used its discretion under the 1135 waiver authority to expand access to telehealth services since patients were reluctant to travel to health care facilities due to the spread of COVID-19. This waiver allowed Medicare to pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence. ACP supported this measure, but we remain concerned that some of the telehealth services expanded under the 1135 waiver, as discussed further later in this statement, are due to expire at the end of the PHE. These telehealth services, which are used by internists to provide evaluation and management services to treat patients' chronic conditions, have been a valuable resource for internists to expand access and coordinate patient care and should remain in place for at least two years after the PHE to ensure that our physicians are able to continue to use this modality to enhance patient care.

We are pleased that Senators Cortez Masto and Young have introduced bipartisan legislation, **S. 3593, the Telehealth Extension and Evaluation Act**, that would expand the telehealth expansions under the 1135 waiver for an additional two years after the end of the PHE. We also appreciate that Representatives Doggett and Nunes have introduced **H.R. 6202, the Telehealth Extension Act of 2021**, that includes a provision to expand 1135 waivers for telehealth services, including Medicare coverage of audio-only telehealth services between physicians and patients, for an additional two years after the PHE declaration expires.

Expand Telehealth Services Under Category 3 of the Medicare Physician Fee Schedule

We are also pleased that the 2021 Medicare Physician Fee Schedule Final Rule provided coverage through the end of the PHE for more than 100 services via the creation of a temporary Category 3 status. In the 2022 Medicare Physician Fee Schedule Final Rule, CMS finalized its proposal to retain all services added to the Medicare telehealth services list on a temporary, Category 3 basis until the end of CY 2023. **ACP supports CMS' retention of all services added to the Medicare telehealth services list on a temporary, Category 3 basis. While the College supports this extension, we strongly recommend that Congress enact legislation to ensure Category 3 be made permanent as to provide for a more consistent and efficient on-ramp for**

new telehealth services to be added. ACP also appreciates the Agency adding coverage for outpatient cardiac rehabilitation to the Category 3 Medicare telehealth services list. The College strongly encourages CMS add coverage for audio-only evaluation and management telehealth services to the Category 3 list and retain these services until at least the end of CY23.

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by CMS to provide additional flexibilities for patients and their doctors by providing payment for audio-only services. During the PHE, Medicare has covered some audio-only services for tele-mental health as well as evaluation and management services provided to patients and will reimburse for both telehealth services and audio-only services as if they were provided in person. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue while still providing appropriate care to patients.

ACP is discouraged to learn that CMS will not continue coverage of audio-only telehealth evaluation and management (E/M) services beyond the PHE, despite mounting evidence about the effectiveness of expanding coverage for these services. While ACP has supported the Agency's actions to provide coverage and payment parity for such telephone services, the College is very concerned about the impact of reversing these changes at the conclusion of the PHE.

We urge Congress to enact legislation to ensure that payment for audio-only telehealth evaluation and management services between physicians and patients will continue for two years after the end of the PHE along with expanded flexibility for an option for CMS or Congress to extend it even further or consider making it permanent, based on the experience and learnings of patients and physicians who utilize these visits.

Geographical Site Restriction Waivers

ACP strongly supported CMS' policy changes to pay for services furnished to Medicare beneficiaries in any health care facility and in their home—allowing services to be provided in patients' homes and outside rural areas. ACP has long-standing policy in support of lifting these geographic site restrictions that limit reimbursement of telehealth services by CMS to those that originate outside of metropolitan statistical areas or for patients who live in or receive service in health professional shortage areas. While limited access to care is prevalent in rural communities, it is not an issue specific to rural communities alone. Underserved patients in urban areas have the same risks as rural patients if they lack access to in-person primary or specialty care due to various social determinants of health such as lack of transportation or paid sick leave, or insufficient work schedule flexibility to seek in-person care during the day, among many others.

We are pleased that in the final 2022 Medicare Physician Fee Schedule Rule CMS is broadening the scope of services for which the geographic restrictions do not apply and for which the patient's home is a permissible geographic originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE. **ACP supports any efforts to expand access to mental and behavioral health services, including allowing beneficiaries to access services from home, or if the technology is not available at home, from a rural health clinic or hospital.**

We appreciate that the Telehealth Extension Act, H.R. 6202, would **permanently lift geographic and site-based restrictions** for additional telehealth services covered under Medicare regardless of a beneficiary's zip code, and in the comfort and convenience of their own home or at designated health facilities offering telehealth. **We urge adoption of this provision that will increase access to telehealth services beyond mental and behavioral health services in any legislation that Congress chooses to advance on telehealth.**

Telehealth Cost Sharing Waivers

ACP appreciated the flexibility previously provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. This critical action has led to increased uptake of telehealth visits by patients. At the same time, we call on CMS, or preferably Congress, to make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining telehealth services, including those related to mental and behavioral health treatment.

The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. **At the conclusion of the COVID-19 PHE, ACP recommends that Congress urge, or if necessary, require CMS to continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service**. This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they reside.

<u>Lower the Cost of Prescription Drugs</u>

ACP has longstanding policy supporting the ability of Medicare to leverage its purchasing power and directly negotiate with manufacturers for drug prices. We supported a provision in H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, that would mandate that the Secretary of Health and Human Services (HHS) identify 250 brand name drugs that lack competition in the marketplace and that account for the greatest cost to Medicare and the U.S. health system and then negotiate directly with drug manufacturers to establish a maximum fair price for a bare minimum of 25 of those drugs. In a 2019 estimate by the Congressional Budget Office,

projections indicated that $456 billion in savings over 10 years would be realized by allowing Medicare to directly negotiate prescription drug prices with manufacturers.

We remain concerned that the House-passed BBBA does not include this more robust provision of price negotiation in H.R. 3. We believe that giving HHS the authority to negotiate drug prices with manufacturers is one of the most effective ways to lower the cost of prescription drugs and we urge lawmakers to include that provision of H.R. 3 or similar legislation in the final bill.

The House-passed BBBA allows HHS to negotiate the price of 10 of the most expensive drugs by 2025 and going up to 20 drugs by 2028 on drugs that are beyond their period of exclusivity. The bill applies an excise tax on drug manufacturers for raising prices faster than the rate of inflation, reduces out-of-pocket expenses for customers and ensures patients pay no more than $35 a month for insulin products. **While ACP reaffirms its support for a full repeal of the noninterference clause, ACP is also supportive of an interim approach, such as allowing the Secretary of HHS to negotiate for a limited set of high-cost or sole-source drugs.**

Conclusion

We appreciate the opportunity to provide our views to the Finance Committee on this important topic that should be addressed as the baby-boomer generation ages and Medicare expenditures are expected to continue to grow in the coming years. We urge the Committee to address the issues in our statement to ensure that Medicare can provide the most efficient and effective care for our nation's seniors and individuals with disabilities. Should you have any questions regarding our statement, please do not hesitate to contact Brian Buckley at bbuckley@acponline.org