June 13, 2024

The Honorable Ron Wyden
Chairman, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American College of Physicians (ACP), I am writing to commend you on your commitment to improving chronic care and appreciate this opportunity to respond to the Senate Finance Committee White Paper on Bolstering Chronic Care Through Physician Payment Current Challenges and Policy Options in Medicare Part B. We hope that this letter will start a bipartisan discussion on how to strengthen chronic care as well as ensure that the Physician Fee Schedule (PFS) provides the resources necessary for our physicians to deliver high quality care to our nation's seniors. We urge the Finance Committee to act on the following recommendations outlined in this letter to achieve these goals.

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 and chronic illness. Additionally, internal medicine physicians comprise the largest share of physicians specializing in primary care, and the largest share of physicians caring for Medicare patients with complex and chronic illness.

We appreciate that the Senate Finance Committee hosted a hearing on Bolstering Chronic Care in Medicare that provided us with an opportunity to share our views on this topic, and particularly the health challenges, cognitive load and high costs associated with chronic care. We urge the Committee to pursue reforms to the Physician Fee Schedule (PFS) that both

improve the delivery of chronic care and ensure that our physician payment system provides the financial stability for our physicians to deliver high quality care for all Medicare patients.

Strengthen Physician Fee Schedule with Updates Consistent with Inflation and Reform Budget Neutrality Requirements

The current PFS does not provide adequate stability and necessary resources for physicians to deliver high quality chronic care for our patients. Unlike nearly every other segment of the Medicare payment system, the PFS does not include annual inflationary adjustments. As a result, when accounting for inflation, current Medicare physician payment rates have decreased by a staggering 29% since 2001. Current payment rates are not sustainable for physicians to cover the basic expenses of their practice including payroll for their staff, maintenance and rent for their office buildings, and the purchase of new health information technology and equipment necessary to advance the quality of health care they provide to their patients.

Congress must ensure that the PFS provides physicians with annual updates consistent with the Medicare Economic Index (MEI), that adequately reflect increased costs in their practice due to inflation. ACP urges Congress to enact legislation this year to end the annual freeze on Medicare physician payments and provide an annual update to the PFS that is consistent with the MEI. Failure to do so could hinder physicians' ability to cover their office expenses and deliver high quality care for Medicare patients with complex chronic illnesses.

Additionally, one of the structural challenges of the current Medicare physician payment system is the statutory budget neutrality (BN) requirement. Under this requirement, any increases to physician services within the PFS final rule, such as those applied to evaluation and management (E/M) services in the 2021 PFS, must be offset by an arbitrary across-the-board BN reduction to all services paid under the PFS. ACP is grateful that Congress has recognized the unfair burden that the BN requirement places on physicians; in the current scenario it would erode the impact of policies in the 2021 PFS addressing undervalued E/M services while also penalizing physicians who do not bill for E/M services. Fortunately, congressional action in the past few years has helped mitigate a substantial portion of the BN cuts, while ensuring that the increased payments to frontline primary and comprehensive care physicians were maintained. However, a longer-term solution is still needed to end this yearly cycle of instability.

These flawed policies have left physicians without consistent, positive, and stable payment updates, and are leading to staffing shortages and service limitations that result in longer wait times or other disruptions in patient care. We ask that you align the Finance Committee's efforts with policies included in the following House bills that address these issues.

H.R. 2474, the Strengthening Medicare for Patients and Providers Act would preserve access to care for Medicare beneficiaries by providing an annual inflation update equal to the MEI for Medicare physician payment. This legislation is essential to physicians' ability to maintain their practices and make needed investments that would ensure they can continue to deliver high quality care to their patients.

H.R. 6545, the Physician Fee Schedule Update and Improvements Act, would allocate 3 percent to the 2024 Medicare conversion factor as well as update the threshold for implementing budget neutral payment cuts in the PFS. It would raise the budget neutrality threshold to $53 million and would use cumulative increases in the MEI to update the threshold every five years afterwards. We believe that this is a practical approach, which would help account for inflation. ACP also supports the provisions in the bill that would require CMS to update the direct costs associated with practice expenses (clinical labor, the prices of equipment, and the prices of medical supplies) simultaneously at least once every five years.

Support Sufficient and Sustained Increases in Medicare Payments for Primary Care Services in a Manner that is not Limited by Current Budget Neutrality Constraints

It is essential that Congress develop policies to provide the financial stability needed to help physicians improve the quality and value of care they furnish. As indicated above, a first step would be modifying the current laws that impose arbitrary payment cuts in the PFS every year. ACP also encourages Congress to develop policies to ensure that the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) fulfills its goal as intended to transform Medicare physician payment from a fee-for-service (FFS) model that pays physicians based on the number of services provided to a value-based model that incentivizes the quality and outcome of care delivered to patients. Yet, we are concerned that these programs have fallen far short of truly shifting payments away from a still predominant FFS model or moving the needle toward achieving greater equity in the delivery of health care.

Based on our 2020 ACP paper, Envisioning a Better U.S. Health Care System for All: Health Care Delivery and Payment System Reforms, we recommend that all payment systems substantially increase relative and absolute payments for primary care commensurate with its value in achieving better outcomes and lower costs. Inappropriate disparities in payment levels between longitudinal complex cognitive care and preventive services, relative to short-term procedurally oriented services, should be eliminated. It is essential that payment policies recognize the value of primary care and chronic disease management in ensuring lower costs and healthier populations., Access to primary care has consistently been associated with higher quality of care, lower mortality rates, higher patient satisfaction, and lower total system costs. Compared with other developed countries, the United States ranked lowest in primary care functions as well as health outcomes, yet highest in health spending. Moreover, studies have shown health

outcomes are better in states with higher ratios of primary care physicians within the population than in those with lower ratios. 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. We must enact policies that do not penalize physicians who provide these essential services and ensure that payment is sufficient to reverse the primary care physician shortage.

Incentivizing Participation In Alternative Payment Models

The congressional intent behind MACRA was to offer physicians and other clinicians increasing opportunities to move into robust, value-based payment programs, including advanced Alternative Payment Models (APMs). Although the Merit Based Incentive Payment System (MIPS) is intended to be an on-ramp to APMs, an on-ramp is meaningful only if there are opportunities for all eligible clinicians to enter an APM arrangement. To date, Medicare has not created enough of these opportunities, and those that are available typically require a practice to take on significant financial risk. Although taking on risk may be a proxy for achieving improved patient outcomes at a reduced cost, it also takes notable and continued financial investment to reach these goals.

ACP published two policy papers, our New Vision for Health Care Delivery and Payment System Reforms and Reforming the Physician Payment System to Achieve Greater Equity and Value in Health Care, that provide our specific recommendations to reform APMs. We urge Congress and CMS to enact the following reforms to ensure additional opportunities for our physicians to participate in APMs.

- Extend the five percent APM participation incentive and halt the revenue threshold increase for five years to encourage more physicians to transition from FFS into APMs.
- Models should have varying levels of risk and reward to appeal to a wide range of practices with differing abilities to take on financial risk.
- Models should reward improvement, as well as consistent high value care. For example, Accountable Care Organizations (ACOs) that already provide high-quality low-cost care have a difficult time continuously improving their performance which makes it challenging to meet their benchmarks.
- Value-based models and programs should undergo regular, independent evaluation to ensure accurate measurement of their impact on cost, quality outcomes, and patient satisfaction.

- Assessment should also consider how well APMs support the quadruple aim of improving outcomes, enhancing patient satisfaction, lowering costs, and improving physician satisfaction.
- Evaluations should be used to improve the accuracy of individual performance metrics and make design improvements to increase a model's ability to effectively drive and capture quality or efficiency enhancements, as well as to recognize when it is time to sunset a particular program or model.
- Medicare must have the flexibility to align existing and novel Innovation Center models quickly and with relative ease to ensure that they are implemented consistently and meet multiple specialties' needs.
- The Innovation Center approach to new model development must also allow greater opportunities to learn and change along the way—rather than having to be fully formulated, which takes a year or more, before implementation of the new model.

In addition to the bill highlights noted earlier in this letter, ACP supports provisions in ***H.R. 6545, the Physician Fee Schedule Update and Improvements Act*** that would extend incentive payments for participation in eligible advanced alternative payment models (APMs) through 2026. The bill includes a provision that would provide the Secretary of Health and Human Services (HHS) with flexibility for tiering bonuses. ACP supports extending incentive payments for APMs to support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value of health care delivered to the patient. Instead of having a tiered approach for bonuses, we recommend that Congress considers freezing the revenue threshold increase for five years to encourage more physicians to transition from fee-for service into APMs and maintain financial viability for those already participating in such programs.

We urge the Senate to approve ***S. 3503/H.R. 7623, the Value in Health Care Act of 2023***. We are pleased that the bill provides a multi-year commitment to reforming care delivery by extending MACRA's 5 percent advanced APM incentives. It also gives the Centers for Medicare & Medicaid Services (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.

Rethinking MIPS

The MIPS component of the 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 structure 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.

We were pleased to share our specific ideas to improve MVPs at a CMS town hall on this topic. Our comment letter concerning the 2023 Medicare Physician Fee Schedule Proposed Rule provides support for the stated goals of MVPs to reduce reporting burden and complexity within MIPS while improving the accuracy and effectiveness of performance measurement, aligning with longstanding ACP priorities. ACP is also working with a group of national and state medical societies convened by the American Medical Association (AMA) to develop policy recommendations to improve MIPS and urge Congress to work with CMS to develop the following reforms to this program.

- Provide flexibility to CMS to set performance thresholds
- Improve the cost performance category
- Provide scoring flexibility to CMS to allow for multi-category credit
- Provide CMS flexibility to score and benchmark measures as appropriate and to test and incentivize new measures and MVPs to ensure successful implementation
- Update the Promoting Interoperability performance category
- Extend the $500 million exceptional performance bonus for an additional six years
- Align comparisons in the MIPS Quality performance category and Physician Compare.

ACP strongly opposes CMS' proposal to raise the performance threshold for avoiding MIPS penalties from 75 points to 82 points. ACP has previously advocated against increasing these threshold requirements, emphasizing that the 75-point threshold was established using 2017 claims data, a year marked by the transition to MIPS. The new threshold is derived from an average of claims data spanning 2017 to 2019. According to CMS' own projections, this adjustment could lead to a higher number of MIPS-eligible clinicians facing penalties, potentially resulting in payment reductions of up to -9 percent. This would greatly harm already-stressed practices and impair their ability to provide essential services to Medicare beneficiaries.

Improving Primary Care and Chronic Care

We remain concerned that despite the implementation of new chronic care management codes in the PFS, which allow physicians to bill services provided outside of face-to-face patient visits, many seniors fail to access chronic care services from their primary care physician. The latest

data reveals that only 4% of Medicare beneficiaries potentially eligible for chronic care management (CCM) received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

We believe that access to chronic care services remains low due to patient cost sharing associated with this code. Current law mandates that Medicare beneficiaries are subject to a 20% coinsurance requirement to receive CCM services. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services and may forego the services altogether as a result.

Physicians who use CCM services are also required to document the amount of time spent with each patient resulting in excessive administrative burdens associated with these codes. We believe that the additional imposed administrative burdens associated with these codes are contributing to the reluctance of physicians to provide and bill for CCM services.

We urge the Finance Committee to work with CMS to remove the burdensome time documentation requirements associated with billing CCM services. A solution to this burden would be to simply require the physician to attest to the amount of time spent providing the service.

We urge you to approve *H.R. 2829, the Chronic Care Management Improvement Act of 2023*. This legislation would remove the cost sharing requirement for patients to access CCM services. We also support allowing the physician that performs CCM services to waive the requirement that the patient pay the 20 % coinsurance fee associated with this service.

Supporting Chronic Care in the Primary Care Setting

In our policy paper Reforming Physician Payments to Achieve Greater Equity and Value in Health Care, ACP recommends that all payers prioritize the inclusion of underserved patient populations and those who are disadvantaged by health care disparities and inequities based on personal characteristics and/or are disproportionately impacted by social drivers of health in all value-based payment models, including population-based prospective payment approaches.

We support aspects of legislation recently introduced by Senators Whitehouse and Cassidy, the Pay Primary Care Physicians (PCPs) Act, S. 4338, that would expand and accelerate the adoption of a hybrid per member per month (PMPM) payment model outside of the PFS. We believe this type of model can enhance innovation and improve the delivery of chronic care in primary care practices. However, we caution the Finance Committee that if this hybrid PMPM payment model is implemented in the PFS, the cost of implementation must be outside the scope of budget neutral payment offsets. We remain concerned that if payment for the hybrid PMPM payment model is implemented in a budget neutral manner, it would only cause a further

erosion of payments to all other services in the fee schedule. We further caution that such models should be voluntary and tested prior to any consideration for implementation into the PFS. Unintended consequences associated with, but not limited to patient attribution, claw backs, and redistribution of funds within the PFS must be accounted for and avoided. Congress should revise requirements for the implementation of budget neutral payment cuts before the implementation of this type of new payment model within the PFS.

We oppose a provision in the Pay PCPs Act that would establish a new Technical Advisory Committee on Relative Value Updates and Revisions as it is divisive in medicine and will only strengthen opposition to the final passage of this legislation.

We have strong concerns with the scope of authority provided to the Technical Advisory Committee in the legislation. Specifically, we are deeply concerned by the committee's proposed duties including the authority to evaluate and determine whether payment codes should be collapsed and whether certain services should be bundled or unbundled. Because of the complexity of issues involving the valuation of medical services, we strongly recommend that the proposed Technical Advisory Committee should be deleted from the PCPs Act of 2024.

Supporting Chronic Care Benefits in the PFS

We were pleased that an initial version of the Pay PCP's Act would waive beneficiary cost sharing for primary care services. The final version of this legislation did eliminate fifty percent of beneficiary cost sharing for primary care services. We appreciate the efforts of the bills sponsors to lower the cost of these services for our seniors but recommend the elimination of all cost sharing for these services. We believe that cost sharing creates barriers to evidence-based, high value, and essential care and should be eliminated, particularly for low-income patients and patients with certain defined chronic illnesses. Evidence shows that even very low Medicaid copayments are associated with decreased use of necessary care. High deductibles may serve as a barrier to receiving high-value, preventive care and treatment after diagnosis.

Ensuring Accuracy of Values within PFS

We strongly believe it is essential to maintain integrity in the Medicare PFS, ensure patients receive high-quality care, and determine accurate payment rates for physicians' services. ACP believes that part of this objective is to make sure we utilize and refine the most appropriate and adequate processes for doing so.

Despite the positive changes for internal medicine physicians as a result of the work of the Relative Value Scale (RVS) Update Committee (RUC), we remain concerned that it has a tendency to value codes primarily on the basis of physical skill or technology used, while undervaluing

cognitive services necessary for the management of complex patients with multiple chronic illnesses (i.e., critical thinking involved in data gathering and analysis, planning, management, decision making, and exercising judgment in ambiguous or uncertain situations).In fact, one study found that Medicare reimburses physicians 3 to 5 times more for common procedures than for cognitive care. In that study, the authors demonstrated that two common specialty procedures, cataract extraction and screening colonoscopy, can generate more revenue in one to two hours of total time than a primary care physician receives for an entire day's work. Although cognitive services are not procedure-intensive (e.g., spinal tap), with technological innovations, mass amounts of data to review, and the role of team-based care, internal medicine physicians and primary care physicians' services (e.g., care coordination for a high-risk patient) are increasingly labor-intensive. The College understands that physicians who primarily provide procedural services also provide a degree of cognitive care, but those physicians who almost exclusively provide cognitive care are deprived of an appropriate accounting due to the RUC's reliance on the metrics of time, intensity, and practice expense alone.

Importantly, these fundamental biases are averse to the critical role that primary care plays in health care and necessary reform to support the provision of continuous, patient-centered, relationship-based care. Without access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels.

As the National Academy of Science Engineering and Medicine (NASEM) report points out, the nation's health is directly linked to the strength of its primary care delivery system and workforce. Unfortunately, the systemic undervaluing of cognitive, including primary care, services is problematic and widespread. As the current payment system drives down the value of primary care, there has been an attrition in the number of physicians practicing primary care, with a greater proportion of trainees choosing to go into procedure-based specialties, resulting in a worsening shortage of primary care physicians. This shortage will, and has had, a profound impact on the availability, access and quality of care and patient health outcomes, particularly for our most vulnerable elderly patients with complex chronic conditions.

We also remain concerned that CMS has routinely overestimated the utilization of new Medicare billing codes that were added to the fee schedule. The most prominent example of CMS overestimating utilization assumptions related to code revaluations occurred when transitional care management (TCM) services were added to the PFS in 2013, which you included in the RFI. CMS estimated 5.6 million new claims would be submitted for these services. Actual utilization, however, turned out to be just under 300,000 claims for the first year and it was still less than

one million claims after three years. As a result of this overestimation for TCM services alone, Medicare physician payments were reduced by more than $5.2 billion from 2013 to 2021.

ACP is requesting that Congress directs the Government Accountability Office (GAO) to conduct a study and report back to Congress on the utilization estimates and actual payments incurred from the implementation of new Medicare codes by the Centers for Medicare and Medicaid Services (CMS). This language is needed to more accurately determine how much money in Medicare Part B was unnecessarily held back versus the actual amount needed to pay for those services within the first year of implementation. The concern is that money is often withheld from the fee schedule due to budget neutrality and if the estimates are above the actual code utilization, that money doesn't get put back into the fee schedule to fund other service costs. If there is an overestimation in utilization of new codes, it can lead to unnecessary physician payment cuts, which ultimately can hinder patients' access to timely care.

Ensuring Beneficiaries Continued Access to Telehealth

ACP supports the expanded role of telehealth as a method of health care delivery that can enhance the patient-physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's health care team, and reduce medical costs. Telehealth can be an option for patients who lack access to in-person primary or specialty care due to various social drivers of health such as a lack of transportation or paid sick leave, or insufficient work schedule flexibility to seek in-person care during the day. Current telehealth flexibilities have been instrumental in improving access to care for patients across the U.S. We were pleased that the Consolidated Appropriations Act of 2023 extended many of those flexibilities through the end of 2024, helping ensure access to care modalities. To preserve patient access to telehealth, Congress must extend these flexibilities beyond this year and consider making them permanent.

ACP Supports S. 2016/H.R. 4189, the Connect for Health Act of 2023

We urge Congress to approve ***S. 2016/H.R. 4189, the Connect for Health Act of 2023***. This legislation would permanently expand access to essential telehealth services including expanding originating sites and lifting geographic requirements for telehealth services and allowing FQHCs and RHCs to continue to provide telehealth services. We previously asked the Finance Committee to include this legislation in the original CHRONIC Care Act and urge you to act to ensure that seniors continue to have access to these vital telehealth services after they expire at the end of this year.

Ensure Access to Audio-only Telehealth Services

We also support ***S. 1636/H.R. 3440, the Protecting Rural Telehealth Access Act as well as H.R. 7623, the Telehealth Modernization Act***, that would ensure that seniors may continue to access audio-only telehealth consults with their physician after this option expires at the end of this year. ACP strongly supports the use of audio-only telehealth as an effective modality to address gaps in health equity. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks or have privacy concerns and do not feel comfortable using video visit technology or do not possess the digital literacy to use video technology.

Conclusion

Thank you for your leadership on these important issues. We hope this letter provides a blueprint for the Senate Finance Committee regarding proposals to improve chronic care and strengthen the PFS. We look forward to our continued conversation with members of this Committee and urge you to act without delay on these recommendations. If you have any questions regarding our response, please contact Brian Buckley, Senior Associate for Legislative Affairs, at bbuckley@acponline.org.

Sincerely,

Isaac O. Opole, MBChB, PhD, MACP
President