Statement of the
American College of Physicians
to the U.S. House Ways and Means Health Subcommittee Hearing
on
Investing in a Healthier America: Chronic Disease Prevention and Treatment
September 18, 2024

The American College of Physicians (ACP) is pleased to provide comments in response to the House Ways and Means Health Subcommittee's hearing on "Investing in a Healthier America: Chronic Disease Prevention and Treatment." We thank Ways and Means Chairman Smith and Health Subcommittee Chairman Buchanan and Ranking Member Doggett for holding this hearing to examine the prevalence of chronic disease in America and the value of investing in prevention and innovative treatment options. We hope these comments will lead to bipartisan action to strengthen chronic care solutions as well as ensure that the Medicare Physician Fee Schedule (MPFS) provides the resources necessary for our physicians to deliver high quality care to our nation's seniors. We urge the Ways and Means Committee to act on the following recommendations outlined in this letter to achieve these goals.

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.

Although passage of the Creating High-Quality Results and Outcomes to Improve Chronic (CHRONIC) Care Act made important changes in improving care for seniors with chronic conditions, additional steps are needed to ensure that our patients have access to high quality chronic care. Six in ten American adults have at least one chronic disease and four in ten have two or more, and at $3.3 trillion in annual health costs, chronic disease is responsible for 75 percent of aggregate national health care spending and is the largest cause of disability and death. General internal medicine physicians assume principal responsibility for coordinating and managing patients' overall care, particularly for those with multiple complex chronic conditions. As the Subcommittee examines policies to bolster chronic care, we urge you to adopt the following measures to ensure lower costs and improve the quality of chronic care in this country:

- Strengthen and Stabilize the MPFS
- Revise Requirements for Budget Neutral Payment Cuts in the MPFS
- Extend Alternative Payment Models (APMs) Incentive Payments

- Ensure Accurate Estimates of Utilization of New Codes in the MPFS
- Remove Beneficiary Cost Sharing for Chronic Care Management Services
- Support Increased Access to Telehealth Services
- Expand the Primary Care Physician Workforce

Strengthen the Medicare Physician Fee Schedule

It is unrealistic to assume that the current MPFS provides the adequate stability and resources necessary for our physicians to deliver high quality chronic care for our patients. Unlike nearly every other segment of the Medicare payment system, the MPFS does not include annual inflationary adjustments. As a result, when accounting for inflation, Medicare physician payments have declined 29 percent from 2001 to 2024. 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. That has made it much harder for physician practices to manage sharp increases in practice expenses or navigate staffing and supply shortages.

The modest statutory updates previously included in MACRA have ended and physicians are in a six-year period with no updates. The result is real reductions to payments when accounting for 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 (MEI). An MEI update for the MPFS would allow physicians to make needed investments in their practices to help ensure that they are able to deliver high quality care to their patients.

Revise Requirements for Implementing Budget Neutral (BN) Payment Cuts in the MPFS

In addition to a lack of inflationary updates, each year physician practices face arbitrary payment cuts due to budget neutrality requirements in the annual fee schedule that, unless addressed in a comprehensive way, will continue to plague physicians in the years to come. Although we appreciate that Congress has provided some financial relief to physicians to mitigate the effect of these payment cuts, these measures do not provide the consistency and stability for physicians to meet their expenses and provide high quality care to seniors.

We urge Congress to act this year to pass the Provider Reimbursement Stability Act, H.R. 6371, which would give the Centers for Medicare and Medicaid Services (CMS) more flexibility in setting payment rates, updating average costs doctors incur in calculating reimbursement and making payments more predictable. The bill would require CMS to conduct a look-back period, to reconcile overestimates and

underestimates in utilizations. We support this approach as it would allow for a more accurate calculation of the Medicare conversion factor based on actual utilization data and claims. Further, it would raise the BN utilization estimate threshold from $20 million to $53 million and would use cumulative increases in the MEI to update the threshold every five years afterwards. The $20 million threshold was established in 1992 and has not been updated since. Raising the BN threshold would allow for greater flexibility in determining pricing adjustments for services without triggering across-the-board cuts in Medicare physician pay. We believe that this is a practical approach, which would help account for inflation.

An alternative bill ACP also supports is H.R. 6475, the Physician Update and Improvements Act. This bill would also raise the threshold for implementing budget neutral payment cuts from $20 million to $53 million and would provide an increased update to the threshold every five years afterwards based on the MEI. 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.

Another provision in this bill we support would allocate three percent to the 2024 Medicare conversion factor, as well as extend incentive payments for participation in eligible advanced alternative payment models (APMs) through 2026 and would tier bonuses according to how long a physician has participated in an APM, to account for increased upfront costs. Further, 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 AP

Pass the Value in Health Care Act to Extend APM Incentive Payments

ACP supports extending incentive payments for participation in eligible alternative payment models through 2026. Congress should pass the Value in Health Care Act of 2023, H.R. 5013, to extend the five percent bonus for physician participation in advanced APMs. This bipartisan legislation makes several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries. The Value in Health Care Act makes a number of important reforms to strengthen Medicare's value-based care models and Accountable Care Organizations (ACOs) to ensure that these models continue to produce high quality care for the Medicare program and its beneficiaries as well as to generate savings for taxpayers. The bill extends MACRA's five percent advanced APM incentives that are scheduled to expire at the end of the year. It 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. This approach

would help to maintain incentives that support physicians' transition from a volume-based fee-for-service health care system to one that is based on the value and quality outcomes of health care delivered to the patient. Another bill we support, H.R. 6369, also extends incentive payments for participation in eligible alternative payment models.

Ensure Accurate Calculation of Utilization of New Medicare Payment Codes

ACP is requesting that Congress directs the Government Accountability Office (GAO) to conduct a study and report on the utilization estimates and actual payments incurred from the implementation of new Medicare codes by 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.

Remove Beneficiary Cost Sharing for Chronic Care Management Services

We remain concerned that despite the implementation of new chronic care management codes in the MPFS, 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 four percent of Medicare beneficiaries potentially eligible for chronic care management received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible beneficiaries.

ACP urges Congress to pass H.R. 2829, the Chronic Care Management Improvement Act of 2023. This legislation would remove the cost sharing requirement for patients to access chronic care management services. 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 percent 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. ACP also supports allowing the physician that performs chronic care management services to waive the requirement that the patient pay the 20 percent coinsurance fee associated with this service.

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 Congress 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.

Protect and Preserve Medicare Beneficiaries' Access to Telehealth Services

ACP supports the use of telemedicine as a method of health care delivery that will improve the health of patients with chronic conditions by enabling and enhancing patient physician collaborations, increasing access to care and members of a patient's health care team, and reducing medical and resource costs when used as a component of a patient's longitudinal care. Telehealth flexibilities from the pandemic-era public health emergency (PHE) 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. ACP believes that the following coverage policies should be continued – and not allowed to expire – to support making telehealth an ongoing and continued part of medical care now and in the future.

- Expand originating sites and lift geographic requirements for telehealth services
- Allow federally qualified health centers (FQHCs) and rural health clinics (RHCs) to continue to provide telehealth services
- Allow the furnishing of audio-only telehealth services for evaluation and management services

We urge Congress to make these existing flexibilities permanent or to provide long-term extensions for them. ACP Supports S. 2016/H.R. 4189, the Connect for Health Act of 2023. This legislation would permanently facilitate access to essential telehealth services by expanding originating sites and lifting geographic requirements for telehealth services and allowing FQHCs and RHCs to continue to provide telehealth services.

We also support S. 1636/H.R. 3440, the Protecting Rural Telehealth Access Act, a bill that would ensure that seniors can 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.

Expand the Primary Care Workforce

It is estimated that there will be a shortage of up to 86,000 physicians by 2036. This includes a shortage of projected supply and demand for primary care physicians of between 20,200 and 40,400 physicians by 2036. As our population ages 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.

ACP appreciates Congress' continued GME expansion with the Consolidated Appropriations Act, (CAA), 2023, which added 200 new GME slots, 100 for psychiatry and psychiatric subspecialties and 100 for other physician specialties. We urge Congress to ensure that this progress does not stall by passing the Resident Physician Shortage Reduction Act of 2023, H.R 2389/S. 1302, which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years.

Conclusion

We commend you for working in a bipartisan fashion to identify ways to improve the delivery and value of health care provided to those with chronic conditions. 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.