James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

October 5, 2023

The Honorable Jason Smith
Chair
Committee on Ways and Means
United States House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the request from the House Committee on Ways and Means' for information (RFI) on ways to improve health care in rural and underserved areas. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA works tirelessly to ensure health care access and coverage for Americans across the nation, especially for the country's most vulnerable patient populations.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

Merit-based Incentive Payment System (MIPS)

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and the Centers for Medicare & Medicaid Services (CMS) to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients. The AMA is strongly recommending that Congress make three key changes to the MIPS program to remedy these problems.

Background

CMS applied automatic hardship exceptions due to the COVID-19 pandemic in 2019, 2020, and 2021, and accepted applications for COVID-19 hardship exceptions in 2022 and 2023. The AMA strongly advocated for and supported policies to hold physician practices harmless from penalties as physicians cared for patients with COVID-19 during multiple surges, postponed non-essential procedures, and established new care delivery systems, including telehealth, to better serve and accommodate patients when feasible. While we supported these much-needed flexibilities, the program was severely disrupted for five years due to unforeseeable circumstances and, as a result, the gradual implementation of MIPS as originally envisioned by Congress in 2015 under MACRA was not realized.

Instead, as MIPS requirements have continued to increase each year and the penalties (now at nine percent) apply in full, CMS expects a substantial rise in the number of physicians who will receive MIPS financial penalties. In the 2024 Medicare Physician Payment Schedule proposed rule, CMS estimates that over half (54 percent) of eligible clinicians (ECs) will receive a MIPS penalty averaging -2.4 percent in 2026. This is in large part due to the proposed increase to the number of points needed to avoid a MIPS penalty in 2024 (the number of points needed now stands at 82 points compared to just 15 points in 2018, the last year that MIPS was fully in effect before the COVID-19 automatic hardship exceptions took effect). Even more alarming, CMS estimates that nearly 65 percent of ECs in solo practices and 60 percent of ECs in small practices would receive a penalty, confirming that this program is penalizing small practices and redistributing those funds to large, well-resourced health systems.

Additionally, we are hearing alarming reports that physicians are receiving penalties in 2024 for the first time in the program, which will compound the proposed -3.36 percent reduction to the conversion factor. We have serious concerns that a lack of awareness of the expiration of the automatic COVID-19 flexibilities unfairly penalizes physician practices and disproportionately impacts small, independent, and rural practices. The AMA is strongly urging CMS to extend the deadline to appeal a MIPS payment penalty and to permit physicians to apply for a COVID-19 hardship exception as part of the appeal, and we believe this is a wakeup call for all policymakers regarding the serious negative unintended consequences of MIPS, particularly on the heels of the COVID-19 pandemic.

Even practices that were historically successful in the program are now expected to receive a penalty in 2024 due to the Cost Category being weighted at 30 percent of MIPS final scores for the first time as the cost measures were not even calculated in the two prior performance years due to COVID-19. Furthermore, physicians had no way to anticipate, monitor, or improve their 2022 cost performance category score because CMS did not share any data about attributed measures, patients, or observed costs until August 2023—more than eight months after the conclusion of the performance period.

In addition to the concerns about the significant increases in MIPS penalties starting in 2024, there is mounting evidence that the program as currently implemented is causing significant administrative burden, raising costs for physician practices, and disadvantaging small, independent, and rural practices, all with no proven improvement on quality outcomes. In fact, the program may be exacerbating health inequities by negatively impacting practices that serve medically underserved populations. In summary:

- **MIPS disadvantages rural and medically underserved populations.** According to the U.S. Government Accountability Office (GAO), practices serving rural and medically underserved patient populations face numerous challenges participating in MIPS, including lack of technology vendor support, high costs of ongoing investments needed for participation, staffing shortages, and challenges staying abreast of changing program requirements. According to another GAO report, similar challenges limit rural practices' abilities to transition to alternative payment models (APMs).
- **MIPS does not correlate with improved quality of care.** A 2022 study in *JAMA* found that MIPS may not even correlate with the quality of care delivered and that physicians caring for more medically or socially vulnerable patients were more likely to receive low scores despite providing high-quality care.
- **MIPS is administratively burdensome and costly.** Researchers found it costs $12,811 and 201 hours per physician, per year to comply with the complex and ever-changing MIPS requirements, and, on average, physicians themselves spent more than 53 hours per year on MIPS-related tasks. These 53 hours are equivalent to a full week of patient visits. The researchers found that the majority of the MIPS activities included reviewing medical records, collecting information from patients, and entering data into the electronic health record.
- **MIPS disadvantages small and independent practices.** Based on our analysis of 2021 MIPS performance data, three times as many clinicians in small practices had MIPS scores resulting in penalties—11.9 percent versus 3.36 percent overall. Further, according to a study in *JAMA*, affiliation with a health system was associated with significantly better 2019 MIPS performance scores.
- **MIPS disadvantages safety net practices and exacerbates health inequities.** According to a study in *JAMA* that looked at the first year of MIPS, physicians with the highest proportion of patients dually eligible for Medicare and Medicaid had significantly lower MIPS scores compared with other physicians.

To be clear, there is no reason to believe that the disproportionately negative impact on small, rural, and safety net practices is due to differences in the quality or cost of care provided to Medicare beneficiaries. As noted above, a 2022 study in *JAMA* found that MIPS may not even correlate with the quality of care delivered and that physicians caring for more medically or socially vulnerable patients were more likely to receive low scores despite providing high-quality care. Rather, this discrepancy can be traced to the administrative burden of participating in MIPS, which has a disproportionate impact on these types of practices with fewer resources. In a 2019-2020 survey, physician practice leaders from a variety of specialties, practice types and locations reported that MIPS caused substantial administrative burden. Key contributing factors cited were constant programmatic changes, data collection and reporting, and interference with patient care.

Recommendations

While CMS has tried to improve the program, such as by introducing the MIPS Value Pathways (MVPs) option, these changes are superficial as the agency believes it does not have statutory authority to remedy these problems directly. **Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, and underserved practices; help practices transition to value-based care; and increase transparency and oversight in the program.** Below we offer three legislative changes that would help to streamline and improve the program, drive quality improvements, and reduce negative impacts on small, rural, and safety net practices, all while reducing unnecessary burden on physician practices.

1. **Congress should mitigate steep MIPS penalties following the COVID-19 pandemic that disproportionately harm small, rural, independent practices and practices that care for the underserved and allow practices to revitalize quality improvement infrastructures.**

To accomplish this aim, the MACRA statute should be amended to:

- Freeze the MIPS performance threshold for three years to prevent steep penalties and allow practices to continue to recover from the effects of the pandemic and transition back to MIPS following a five-year interruption due to COVID-19. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program. Congress should use the 2021 performance threshold of 60 points (out of 100), which CMS established as a transitionary policy to encourage participation on all MIPS measures.
- Eliminate MIPS win-lose style payment adjustments and instead link physicians' MIPS performance to an annual inflation-based payment update (e.g., tied to the Medicare Enrollment Index (MEI)). Specifically, physicians could be subject to up to a one-quarter reduction in their update based on their MIPS performance, which would be consistent with the Hospital Inpatient Quality Reporting Program.
- Reinvest money from penalties both in bonuses for high performers, as well as investments aimed at assisting under-resourced practices with their value-based care transformation, with an emphasis on small practices, rural practices, and practices that care for underserved patients.

2. **Congress should hold CMS accountable for timely and actionable MIPS and claims data.**

Congress recognized the importance of timely data to drive performance improvement, which is why it originally mandated under MACRA that CMS must provide timely (i.e., quarterly) MIPS quality and resource use feedback, as well as claims data to physician practices, similar to the types of data provided to Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs).[1] Despite this requirement, physicians did not receive their most recent MIPS Feedback Report based on 2022 performance from CMS until August 2023. These reports are also high-level summary reports. No physician in MIPS has ever received Medicare claims data similar to what MSSP ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. This means that physicians do not know in real time or even on a quarterly basis which cost measures are being attributed to them, which patients are being assigned to them, and what costs outside of their practice they are being held accountable for until well after the performance year is already over, making it impossible for them to leverage this data to implement changes that would improve patient care, outcomes, and use resources more efficiently, saving costs. Furthermore, an in-depth analysis of 2021 MIPS performance data also revealed concerning data inconsistencies too extensive to elaborate on here.

Accordingly, the AMA urges Congress to exempt from penalties any ECs who do not receive at least three quarterly MIPS feedback and claims data reports during the performance period.

3. **Congress should make MIPS more clinically relevant while reducing burden.**

[1] §42 USC 1395w-4(q)(12).

As discussed above, MIPS is unduly burdensome and has not been shown to improve clinical outcomes or reduce unnecessary costs. Moreover, the program does not prepare physicians to move to APMs.

Therefore, we recommend that Congress amend the statute to solve these problems by:

- Removing siloes between the four MIPS performance categories to allow for multi-category credit, therefore reducing burden.
- Bringing MIPS into alignment with other CMS value-based programs to better align with and support care provided in hospitals and other care settings.
- Recognizing the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via attestation of using certified electronic health record technology (CEHRT) or technology that interacts with CEHRT, participation in a clinical data registry, or other less burdensome means. The attestation of using CEHRT is consistent with the hospitals' requirements in Promoting Interoperability, as well as current APM requirements.
- Enhancing measurement accuracy and clinical relevance, particularly within the cost performance category, to target variability that is within the physician's ability to influence.
- Aligning cost and quality goals. MIPS rarely evaluates quality and cost on the same patients and for the same conditions, which has been a key factor inhibiting its ability to drive clinical improvement. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. Harmonizing these measures would ensure MIPS is driving high-value care as intended while reducing burden on physician practices.
- Improving quality measurement accuracy by awarding credit for testing new or significantly revised measures, including Qualified Clinical Data Registry measures, for up to three years.

The AMA strongly believes that each of these policy changes is essential to improve the clinical relevance of MIPS; provide a bridge to transition to APMs; and promote the intended goals of MACRA to leverage health information technology, improve quality, and reduce Medicare costs while reducing burden on physician practices more effectively. **Notably, none of these recommendations are expected to score.** We welcome the opportunity to discuss these recommendations in greater detail.

Need for Inflationary Based Updates to Physician Payment

In recent years, patient access to health care has worsened due to many factors. Patients are grappling with the reality of increasing facility closures, exacerbated travel requirements, and prolonged wait times. Central to this issue is a combination of factors such as consolidation of health care entities and a shortage of physicians and other health care professionals. This access problem is disproportionately more onerous for individuals in rural and underserved pockets of the nation.

The physician payment system is on an unsustainable path that threatens patients' access to physician services. Last year, physicians faced yet another round of real dollar Medicare payment cuts triggered by the flawed Medicare budget neutrality rules and congressional PAYGO rules. Congress acted at the last minute to avert portions of the 8.5 percent cut, but did not stop the cuts completely. Physicians were cut by two percent in 2023 with an additional 3.36 percent reduction to the conversion factor proposed for 2024. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, **Medicare physician payment rates fell 26 percent** from 2001 to 2023 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2023 annual report, the Medicare Trustees "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the system. The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The current Medicare physician payment system—with its lack of an adequate annual physician payment update—is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting

economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, CMS projects that the costs to run a medical practice will increase by 4.5 percent in 2024, while physician payment is on pace to be cut.

We appreciate that Congress passed legislation that, again, averted severe Medicare payment cuts that, if enacted, would have severely impeded patient access to care in 2023. However, this pattern of last-minute stop gap measures must end. Last year, the AMA responded to a bipartisan **Congressional RFI** on strategies that federal lawmakers should consider to stabilize Medicare physician payment, reduce regulatory burden, and improve the MIPS and APM programs. As the Committee looks to provide adequate payments to physicians, particularly those in rural and underserved areas, **annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation. Additionally, the Medicare budget neutrality rules should be reformed to reduce the near-constant threat to physician payment caused by routine updates to the payment system, such as updates to the costs of clinical labor or supplies and equipment.**

We urge lawmakers to consider the pressing need for adequate payments to physicians. Specifically, we ask Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care. Without such updates, the disparity between Medicare physician payment rates and the actual costs associated with delivering high-quality care will continue to grow.

The AMA is engaged with our national specialty and state medical association Federation partners to determine the best path forward to reforming the Medicare physician payment system to make it more rational and sustainable. The AMA, along with our Federation partners, developed the Characteristics of a Rational Medicare Physician Payment System, endorsed by over 120 state medical and national specialty societies, including those representing primary care, surgical care, and other medical specialties. This core set of principles serves as the basis for reforming the broken physician payment system. We are also working to increase awareness of the problems in the current system among Members of Congress and look forward to working with you to seek permanent solutions.

Improvements to Budget Neutrality

Physician payments are further eroded by frequent and large payment redistributions caused by budget neutrality adjustments. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these misestimates are not adjusted in a timely way, it results in permanent removal of billions of dollars from the payment pool. Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for misestimates and adjust the conversion factor to reflect actual claims data.

In addition, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $53 million to best account for past inflation.

Aligning Sites of Service

Patients receive outpatient medical services in a variety of settings, including physician offices, hospital outpatient departments (HOPD) and ambulatory surgical centers (ASCs). With some exceptions, payment rates for outpatient services furnished in hospital facilities are higher than rates paid to physician offices or ASCs for providing the same service. The scope of the payment differential varies, depending on the service or procedure.

Payment differentials between HOPDs and independent physician practices stem from several factors, but most notably from inadequate Medicare physician payment rates. As mentioned above, Medicare physician pay has barely budged over the last two decades, increasing just nine percent from 2001 to 2023, or just 0.4 percent per year on average. In comparison, Medicare hospital pay has increased roughly 70 percent between 2001 and 2023, with average annual increases of 2.5 percent per year for inpatient services and 2.4 percent for outpatient services. Notably, the cost of running a medical practice has increased 47 percent between 2001 and 2023, or 1.7 percent per year. Unlike nearly all other Medicare providers, physicians do not receive an annual inflationary payment update. When adjusted for inflation, which has been at levels not seen since the 1980s, Medicare physician pay has declined 26 percent from 2001 to 2023, or by 1.3 percent per year on average. CMS projects the increase in the costs to run a medical practice will be 4.5 percent next year but at the same time, physicians face a 3.36 percent reduction to the Medicare conversion factor in 2024.

Achieving site-neutral payments for outpatient services and procedures will require increases in Medicare physician payment, so that practices can be sustained, and patient choice of care setting is safeguarded. Many policy proposals over the years have recommended simplistic, across-the-board solutions to the site-of-service differential that reduce payments to all sites to rates paid in the least costly setting (i.e., lowering all services in the HOPD to PFS rates). However, shrinking payments to the lowest amount paid in any setting does not help physicians. The AMA does not believe it is possible to sustain a high-quality health care system if site neutrality is defined as shrinking all payments to the lowest amount paid in any setting. As a result, the AMA advocates strongly that Congress allocate additional funds into the Medicare physician payment system to address increasing physician practice costs. Specifically, the AMA and organized medicine strongly support H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," and urge Congress to provide physicians with much needed fiscal stability by passing this legislation, which provides an inflation-based payment update based on the MEI.

HEALTH CARE WORKFORCE AND GRADUATE MEDICAL EDUCATION (GME)

There is a projected shortage of between 54,100 and 139,000 physicians by 2033 on top of this 17,396 providers are needed to eliminate current primary care Health Professional Shortage Areas. This is particularly alarming since it is projected that there will be about a quarter fewer rural physicians practicing by 2030. In order to help curtail this shortage **more rural residency positions should be created**. "Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training." Unfortunately, the physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28 percent between 2002 and 2017. This decrease is compounded by the fact that in 2016 and 2017 only 4.3 percent of incoming medical students were from rural backgrounds.

In order to encourage more physicians to practice in rural and underserved areas, we recommend that:

- Congress should act to allow the cap on GME slots to be increased as needed to meet the changing needs of our country rather than remain stagnant. Also, the cap building period should be increased. With this in mind particular consideration should be given to increasing slots for specialties that are experiencing shortages like pediatric mental health physicians, to improve access to critical mental health services.
- The immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government. Moreover, the Teaching Health Center Graduate Medical Education, Rural Residency Planning and Development Programs, the National Health Service Corps, and the Indian Health Service should have their funding increased to expand scholarships, loan forgiveness, and expand these programs.
- Support should be provided so that more institutions are incentivized to create rural training track programs.
- Holistic changes to the rural physician working environment need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound rural clinical preceptorships and rotations consistent with educational and training

requirements and provide early and continuing exposure to those programs for medical students and residents. Finally, once individuals choose residencies in rural areas, support systems are needed.

To help alleviate the current and impeding physician shortage we strongly support:

- H.R. 2389/ S. 1302 the "Resident Physician Shortage Reduction Act," which would increase Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots.
- H.R. 4942/ S. 665 the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, as well as expand the total number of waivers available per state and make other targeted improvements to the program.
- H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act," bipartisan legislation that permits borrowers in medical or dental internships or residency programs to defer their student loans until completion of their educational training.
- H.R. 2761/ S. 705 the "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act," would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.
- S. 1403/ H.R. 3046 the "Medical Student Education Authorization Act," would reauthorize the MSE Program which provides grants to expand or support graduate education for physicians.
- Legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities. This would simultaneously achieve the important goal of diversifying the physician workforce in terms of economic background and geographic representation.
- Physician Shortage GME Cap Flex legislation, which would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages.

Support for Physician-Led Teams

Physician-led teams should be provided with additional support and any legislative efforts that inappropriately seek to expand the scope of practice of nonphysician providers beyond their clinical training must be rejected. Far too often, federal and state policymakers seek to address the physician shortage, especially in rural areas, by turning to nonphysician personnel. We urge the Committee to reject any efforts by nonphysician organizations to use this RFI and claims of a diminished physician workforce as a rationale to support expanded scope of practice.

Despite claims to the contrary, **expanding the scope of practice for nonphysician practitioners does not increase patient access in rural or underserved areas.** In reviewing the actual practice locations of primary care physicians compared to nonphysician practitioners, it is clear that physicians and nonphysicians tend to practice in the same areas of a state. This is true even in those states where, for example, nurse practitioners can practice without physician involvement. These findings are confirmed by multiple studies, including state workforce studies. The data is clear—scope expansions have not led to increased access to care in rural and underserved areas.

While all health care professionals play a critical role in providing care to patients and nonphysician practitioners are important members of the care team, their skill sets are not interchangeable with those of fully educated and trained physicians. This is fundamentally evident based on the difference in education and training between the distinct professions.

- Physicians complete four years of medical school plus three to seven years of residency, including 10,000-16,000 hours of clinical training.
- Nurse practitioners, however, complete only two to three years of graduate level education, have no residency requirement, and complete only 500-720 hours of clinical training.
- Physician assistants complete two to two and half years of graduate level education with only 2,000 hours of clinical care and no residency requirement.

- Certified registered nurse anesthetists complete two to three years of graduate level education, have no residency requirement, and complete only 2,500 hours of clinical training.
- Certified nurse midwives must have an RN license and have completed a master's program, which typically lasts two to three years. There is no residency requirement and no specific hours of clinical experience required for graduation, rather the accrediting body provides suggested guidelines for programs.
- Clinical nurse specialists complete a master's degree but there is no residency requirement and only 500 clinical hours of training are required.

But it is more than the difference in hours and years of training—the depth and breadth of physicians' education is far beyond that of nonphysician practitioners. Equipped to handle any clinical scenario as the most highly trained health care professional, physicians are the appropriate leaders of the health care team. The reality is that nonphysician practitioners do not have the education and training needed to be the head of the care team and our nation's patients deserve physician-led care.

In line with this, we strongly oppose:

- H.R. 2713/ S. 2418 the "Improving Care and Access to Nurses Act," or the "I CAN Act." This legislation would expand the scope of practice for nonphysician practitioners.
- H.R. 1779 the "Equitable Community Access to Pharmacist Services Act," which would allow pharmacists to perform services that would otherwise be covered if they had been furnished by a physician, test and treat patients for certain illnesses, and expand Medicare payment for pharmacists.
- S. 799/ H.R.1610 the "Chiropractic Medicare Coverage Modernization Act of 2023," which would amend the Social Security Act's definition of physician to extend Medicare coverage for services furnished by chiropractors beyond the manual manipulation of the spine.

Many of these bills fall within the jurisdiction of the Ways and Means Committee and should be ultimately rejected based on a combination of concerns centered on undermining patient safety, unnecessary utilization of scarce Medicare dollars, while **not** increasing patients' access to the quality care they deserve in rural or underserved areas.

INNOVATIVE MODELS AND TECHNOLOGY

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services by patients with Medicare and extend Medicare's five percent incentive payments for physicians participating in APMs by passing the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/ H.R. 4189) and the Value in Health Care Act (H.R. 5013).

Introduced by Representatives Mike Thompson (D-CA) and David Schweikert (R-AZ) on the Ways and Means Committee, the CONNECT Act is bipartisan legislation which would permanently extend many important COVID-19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. These COVID-19 policies have allowed patients, especially individuals living in rural areas, to obtain telehealth services at home instead of having to travel to a medical facility to receive telehealth services from a distant site, and enabled patients to access health care services through audio-only visits when they do not have reliable access to audio-video telecommunications technology. They have allowed patients with Medicare in non-rural underserved areas to have access to telehealth services for the first time. Access to telehealth services has lowered barriers that many patients in rural and underserved areas face in obtaining in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare.

While the CONNECT Act does not extend every flexibility enacted in response to the COVID-19 public health emergency, it does permanently remove the antiquated geographic restrictions and enable Medicare patients, both in urban and rural areas, to access telehealth services wherever they can access a telecommunications system. As a result, patients will no longer have to travel to originating sites to access virtual care. The legislation also repeals the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within six months of an initial telemental health visit. While federal lawmakers have, thus far, passed legislation delaying this

mandate from coming to fruition, it is crucial this policy is permanently removed to ensure patients retain ample access to telemental health services.

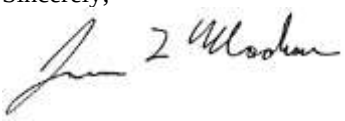
The dramatic increase in the availability of telehealth services has also produced innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of service modalities to meet their health care needs. These models can also reduce fragmentation in care by allowing patients to obtain telehealth services from their regular physicians instead of having to utilize separate telehealth-only companies that may not coordinate care with patients' medical home.

The VALUE Act is bipartisan legislation to help facilitate greater physician participation in APMs, which are intended to accelerate the delivery of high-quality care and generate savings for the Medicare program. Introduced by two prominent members of the House Ways and Means Committee, specifically Representatives Darin LaHood (R-IL) and Suzan DelBene (D-WA), the bill will, among other things, continue the traditional five percent APM incentive payments that were included in MACRA for two more years and freeze the 50 percent revenue threshold that physicians in value-based care models must meet to qualify for these payments. Absent Congressional intervention the Advanced APM incentive payments expire, and the revenue thresholds jump from 50 to 75 percent on January 1, 2024.

To date, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. The models implemented to date often have steep financial risk requirements, lack funding needed to successfully redesign care delivery, and are usually only available in selected regions. In addition, because these APMs must demonstrate Medicare program savings within a short timeframe, they are often terminated instead of being improved and expanded nationwide. In a report on practices in rural or underserved areas, the Government Accountability Office noted that many lack the capital to finance the upfront costs of transitioning to an APM and face challenges acquiring or conducting data analysis necessary for participation. Passage of the VALUE Act can help address these problems.

The AMA thanks the Committee for this RFI and for the careful consideration of solutions to improve patient access to health care throughout our country. We look forward to working with the Committee and Congress to seek bipartisan policy solutions.

Sincerely,



James L. Madara, MD

cc: The Honorable Richie Neal