STATEMENT

of the

American Medical Association

U.S. Senate

Committee on Finance

Re: Bolstering Chronic Care through Medicare Physician Payment

April 11, 2024

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The American Medical Association (AMA) appreciates the opportunity to submit this Statement for the Record for the U.S. Senate Finance Committee hearing entitled "Bolstering Chronic Care through Medicare Physician Payment." This hearing signifies a critical step forward in the ongoing endeavor to modernize traditional Medicare, focusing on the management and treatment of chronic illnesses and the payment structures for physicians and other health professionals. The AMA commends the Committee for its dedication to enhancing Medicare's support for individuals with chronic conditions, such as cancer, diabetes, and heart disease. This commitment was exemplified by the passage of the CHRONIC Care Act in 2018, which instituted comprehensive policy improvements to better meet the complex health care needs of seniors. The AMA is fully supportive of these efforts to update and strengthen Medicare and looks forward to collaborating with the Committee to aid in shaping policies ensuring high-quality, sustainable care for future generations.

CHRONIC CARE MANAGEMENT IMPROVEMENT ACT OF 2023

The AMA supports H.R. 2829, the Chronic Care Management Improvement Act of 2023, which is a critical avenue for enhancing chronic disease management within the Medicare program. This legislation, aimed at eliminating patient cost-sharing for Chronic Care Management (CCM) services, addresses a significant barrier that has hindered the widespread adoption of these essential services. Despite the demonstrated benefits of CCM in improving patient outcomes and reducing hospitalizations, the latest data points to a stark underutilization, with only four percent of eligible Medicare beneficiaries receiving CCM services representing only 882,000 out of an estimated 22.5 million.

In addition to the legislative removal of cost-sharing obligations, a concerted effort by the Centers for Medicare & Medicaid Services (CMS) to partner with states could further increase access to CCM services. This could be achieved through the inclusion of CCM services in state Medicaid plans. Such measures would not only amplify the reach of CCM but also enhance patient engagement in self-management of their health conditions to prevent exacerbations, particularly for those managing chronic diseases.

Waiving patient cost-sharing for CCM services is an important step towards removing obstacles to care management services, including patient-initiated navigation (PIN), and ensuring that Medicare beneficiaries receive the comprehensive care coordination they require. This legislative action, coupled with enhanced CMS and state collaboration, can improve the use of CCM services and health outcomes for millions of Americans living with chronic conditions.

AMA'S COMMITMENT TO PREVENTING AND TREATING CHRONIC DISEASE

Chronic disease is a leading cause of death and disability in the United States (U.S.). According to the Centers for Disease Control and Prevention (CDC), each year more than 877,500 Americans die of heart disease or stroke, more than 1.7 million people are diagnosed with cancer, and more than 37.3 million Americans have diabetes, with an additional 98 million adults diagnosed with prediabetes, which puts them at risk for type 2 diabetes.[1] CDC estimates indicate that these diseases, along with other conditions such as obesity, Alzheimer's, and mental health issues, place a significant burden on the economy, accounting for 90 percent of our nation's $4.1 trillion in annual health care spending. These figures will undoubtedly worsen as the population ages.[2]

The AMA is committed to improving the health of the nation and reducing the burden of chronic diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death in the U.S., accounting for one in four deaths among adults. Two major risk factors for CVD are hypertension and type 2 diabetes. CVD risk factors and associated morbidity and mortality inequitably impact Black, Hispanic/Latinx, Indigenous, Asian/Pacific Islanders, and other people of color. While specific causes of the inequities vary by each respective group, structural and societal barriers are attributed as primary reasons.

To prevent CVD and address related health inequities, the AMA is developing and disseminating CVD prevention solutions in collaboration with health care and public health leaders. These solutions educate clinical care teams and patients, guide health care organizations (HCOs) in clinical quality improvement and promote policy changes to remove barriers to care. The AMA disseminates these solutions through strategic alliances with various organizations, including the CDC, the American Heart Association (AHA), and West Side United in Chicago. Another CVD risk is obesity which is associated with cardiovascular disease mortality independent of other cardiovascular risk factors. The AMA is working with other medical societies, including the American College of Physicians and the Obesity Medicine Association, to identify opportunities to improve access to evidence-based obesity treatments. The AMA supports H.R. 4818, the Treat and Reduce Obesity Act, which would provide Medicare beneficiaries with access to safe, effective, and life-saving treatments. The bill aims to effectively treat and reduce obesity in older Americans by enhancing Medicare beneficiaries' access to health care professionals who are best suited to provide intensive behavioral therapy and by allowing Medicare Part D to cover Food & Drug Administration (FDA)-approved anti-obesity medications.

PREVENTIVE HEALTH SAVINGS ACT

Allowing Congress the ability to look at the financial impact of preventive health legislation beyond the 10-year CBO scoring window is another important tool that is critical for addressing chronic conditions in this country. Consequently, the AMA has endorsed S. 114/H.R. 766, originally named as the Preventive Health Savings Act, and renamed in the House of Representatives as the "Dr. Michael C. Burgess Preventive Health Savings Act." Congress should be able to consider the long-term economic benefits of legislation that promotes wellness and disease prevention and reduces the incidence of chronic conditions, yet it is constrained from doing so by the 10-year CBO scoring window. This legislation will importantly provide the Chair and Ranking Member of either budget or health-related committees in the House and Senate with the ability to request an analysis of the two 10-year periods beyond the existing initial 10-year window. Furthermore, the legislation's definition of "preventive health" appropriately captures the

[1] https://www.cdc.gov/chronicdisease/about/costs/index.htm.
[2] Id.

unique nature of this concept by including actions that focus on the health of the public, individuals, and defined populations to protect, promote, and maintain health and wellness, as well as prevent disease, disability, and premature death as demonstrated in credible, publicly available studies and data. It is widely recognized that preventing a chronic condition will improve health outcomes, reduce costs to our health care system and provide patients with a better quality of life. It is well past time for the CBO to have a scoring methodology that accurately accounts for these long-term economic benefits.

PREVENT DIABETES ACT

The CDC's National Diabetes Prevention Program (DPP), which has the objective of decreasing the incidence of patients developing Type 2 diabetes by incorporating behavioral counseling, exercise, and nutrition counseling, is a proven program that has demonstrated a decrease in the incidence of patients with pre-diabetes, thereby reducing the incidence of Type 2 diabetes. This successful program was the first pilot approved by the Centers for Medicare and Medicaid Innovation (CMMI) for expanded Medicare coverage and is known as the Medicare Diabetes Prevention Program (MDPP). The limitations Medicare has placed on the MDPP have reduced uptake of these important diabetes prevention services and thereby limited the success of the program in preventing the incidence of Medicare beneficiaries with pre-diabetes. As of the end of 2022, cumulative MDPP enrollment stood at 4,848 Medicare beneficiaries, which is striking considering more than half a million individuals participate in the CDC's National DPP program when offered through their health plan or employer. Many Congressional districts lack in-person MDPP locations to serve the tens of thousands of at-risk constituents otherwise eligible for these services under Medicare. Almost one in three adults aged 65 and older have diabetes. According to CMS, medical care for seniors with diabetes and its complications cost the U.S. $205 billion in 2022, most of it paid by Medicare. According to the CDC, some 98 million Americans have prediabetes, including 27.2 million who are aged 65 and older. Without a significant course correction, those numbers will only grow. Consequently, the AMA has endorsed H.R. 7856, the PREVENT DIABETES Act. This legislation, which would broaden access to diabetes prevention services by aligning the MDPP with the CDC's DPP, make MDPP a permanent benefit in Medicare, ensure seniors can participate in the program more than once, and expand access to all CDC-recognized delivery modalities, including virtual diabetes prevention platforms in the program, will help ensure that the full potential of this program to reduce the incidence of Medicare beneficiaries with pre-diabetes, and prevent Type 2 diabetes, is realized.

PRESERVING PATIENT ACCESS TO CARE THROUGH PHYSICIAN FINANCIAL STABILITY

Need for an Inflation Based Update to Physician Payment

For services provided to Medicare beneficiaries in the first two months of the year, physicians' payments were cut 3.37 under current law. We appreciate Congress for acting to partially mitigate that reduction, however as of March 9th, physicians are still experiencing a Medicare cut of nearly two percent. At the same time, the cost of practicing medicine is rising at the fastest rate in decades, as CMS estimated the cost to run a medical practice increased by 4.6 percent in 2024. An inflation-based update to physician payment is critical to change the unsustainable trajectory of the current payment system, which not only jeopardizes patients' access to physician services but also poses significant challenges in managing chronic conditions effectively. The consequences of the continued real-dollar cuts to Medicare payments, exacerbated by the absence of statutory updates aligned with the inflation in medical practice costs and the problems with Medicare's budget neutrality rules has resulted in a 29 percent decline in physician payments adjusted for inflation in medical practice costs since 2001.

Physician practices cannot continue to absorb increasing costs while their payment rates dwindle. In multiple annual reports, the Medicare Trustees have stated that they "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 in 2023, 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 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.

Hospitals, skilled nursing facilities, and nearly every other Medicare provider receive an automatic annual update tied to inflation. Physicians compete in the same marketplaces as these providers for clinical and administrative staff, equipment, and supplies. Yet physicians are at a significant disadvantage due to payment cuts and because their payments have failed to keep up with inflation. Furthermore, hospitals have multiple sources of relief during times of high inflation, including the 340B program and Disproportionate Share Hospital (SDH) payments to account for uncompensated care. It is no wonder that these trends are driving consolidation, which is highly likely to increase future Medicare costs as these other providers receive increasingly higher payments than the diminishing number of independent medical practices. A recent AMA analysis shows that by far, the most cited reason that independent physicians sell their practices to hospitals or health systems had to do with inadequate payment. Next were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources. The AMA strongly supports policies that promote market competition and patient choice. Payment adequacy is necessary for physicians to continue to have the ability to practice independently.

In its recent March Report to Congress, the Medicare Payment Advisory Commission (MedPAC) called for a physician payment update tied to the Medicare Economic Index (MEI) in 2025, following a similar recommendation for increasing physician payment in 2024. Unlike the temporary patches that Congress has adopted in recent years, MedPAC calls for permanent updates to physician payment that would be built into subsequent years' payment rates. While the AMA has commended the Commission for taking this significant step, we note that implementing an inflation-based update based on only half of the full MEI growth rate, as recommended, would be a missed opportunity to meaningfully address the perennial issue of Medicare physician underpayment that threatens stable access to care for millions of Medicare beneficiaries.

We continue to believe that MedPAC's rationale that half of MEI is sufficient because the practice expense component of physician payment accounts for approximately half of total Medicare physician payments reflects an incomplete picture of the cost of running a medical practice. It is well understood that the practice expense component does not cover all practice costs. For example, in the 2024 Medicare Physician Payment Schedule (MPS) final rule, the Centers for Medicare & Medicaid Services (CMS) applies a direct cost scaling adjustment of 0.4637. In other words, for a supply that costs $100, CMS will include $46.37 or a reduction of $53.63 from the invoice cost of the item in the direct expense allocation for the service. Additionally, practice expense is only one component of a multifactorial formula to compensate physicians for the total costs of running a medical practice and caring for Medicare beneficiaries. Payment for physician work—the time, energy, and expertise devoted to treating patients by physicians, nurse practitioners, physician assistants and other qualified health care professionals—is no less important, also contributes to total cost in the provision of a service and is equally impacted by

inflation. Therefore, an inflation-based payment update is equally warranted for physician work and other aspects of total physician payment, all of which could be addressed by finalizing an update that is tied to full, rather than half, of MEI.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, these temporary, partial patches are a distraction, exacerbate budgeting challenges for practices, and divert resources that both medicine and Congress could be spending on other meaningful health care policies and innovations. Therefore, organized medicine is united in support of a long-term payment solution that centers on annual inflationary updates**. 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.

Improvements to Budget Neutrality

Another way to help ensure physicians have ample resources to provide more care in the home is via reforms to statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The AMA urges the Senate Finance Committee to introduce companion legislation to H.R. 6371, the Provider Reimbursement Stability Act. The House Energy and Commerce Committee has taken action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023. The reality is that physician payments are further eroded by frequent and large payment redistributions caused by these 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. Further, Congress should limit the year-to-year variance in the Physician Fee Schedule conversion factor due to budget neutrality to a no greater than 2.5 percent increase or decrease. This would help to add more stability and predictability to the physician payment system.

Reduce Burdens in Merit-based Incentive Payment System (MIPS) and Provide Access to Key Data

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and 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 and the Change Healthcare cyberattack. 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.

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; ensure access to timely data; reduce unnecessary burdens; and increase clinical relevance to physicians and their patients. Specifically, we recommend the following legislative changes:

1. Mitigate steep MIPS penalties following the COVID-19 pandemic and Change Healthcare cyberattack that disrupted MIPS implementation and prevent financial disaster for small, rural, and underserved practices.
2. Hold CMS accountable for timely and actionable MIPS and claims data.
3. Enhance measurement accuracy and validity, align cost and quality performance, and promote clinical data registries and other promising technology to making MIPS more clinically relevant while reducing burden.

We urge Congress to consider these recommendations and look forward to collaborating closely on these critical issues to ensure that health care providers, especially those in rural and underserved areas, are supported effectively through the MIPS framework.

Alternative Payment Models

Value-based Alternative Payment Models (APMs) have a successful track record of improving health outcomes and reducing costs. The AMA supports S. 3503/ H.R. 5013, the Value in Health Care (VALUE) Act, introduced by Senators Whitehouse (D-R.I.) and Barrasso (R-Wyo.) in the Senate and Representatives Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House that would extend the 5 percent APM bonus and maintain the 50 percent revenue threshold for two years.

This bipartisan legislation would help ensure that physicians in communities across the country have meaningful incentives to participate in alternative payment models that will deliver high quality, coordinated health care for patients. APMs have played a key role in providing high-quality care for Medicare beneficiaries while producing billions of dollars in savings for taxpayers over the past decade.

The AMA urges Congress to build on the success of current APMs by finding additional pathways to help develop a more robust pipeline of APMS available to all types of physicians in all geographics locations in the country.

ELIMINATING EFT FEES TO STREAMLINE HEALTH CARE PAYMENTS

The AMA urges the Committee to consider the passage of the “No Fees for EFTs Act” as a crucial step towards enhancing the efficiency and effectiveness of chronic care management across the U.S. By addressing this legislative issue, the Committee would not only be supporting the financial sustainability of health care practices but also contributing to the broader goal of improving care for patients with chronic conditions.

The burden of electronic funds transfer (EFT) fees, as outlined in our support for H.R. 6487, the "No Fees for EFTs Act" in the House, and support for S. 3805, the corresponding Senate bill, highlights a significant barrier to the efficient operation of health care practices. EFT fees, often amounting to two to five percent of the claim payment, are levied by certain health plans and their intermediaries without a clear agreement from health care practices. This not only exacerbates the financial strain on these practices but also diverts valuable resources away from patient care and resources that are crucial for the management of chronic illnesses. In addition, for health care providers in rural and underserved areas, where chronic conditions are prevalent and resources are scarce, the impact of these fees is even more pronounced. These areas frequently face challenges in accessing comprehensive care, and administrative inefficiencies only serve to exacerbate these disparities.

By eliminating EFT fees, the "No Fees for EFTs Act" would significantly reduce administrative complexities, freeing up resources that could be better allocated toward patient care. This is especially important in chronic care management, where continuous, comprehensive care is necessary for managing long-term health conditions. The reduction of administrative burdens would allow health care providers to invest more time caring for patients.

TELEHEALTH ACCESS THROUGH LEGISLATIVE REFORM

The AMA supports the role of telehealth in managing chronic illnesses and advocates for the permanent removal of restrictions limiting Medicare patients' access to these services. Through legislative proposals such as the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/H.R. 4189) and the Telehealth Modernization Act (H.R. 7623), there is a pathway for permanency of the advances made in telehealth accessibility, particularly vital for patients managing chronic conditions.

Introduced by Senators Schatz (D-HI) and Wicker (R-MS), the CONNECT for Health Act is bipartisan legislation that would permanently extend many important COVID-19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID-19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services for the first time. COVID-19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology.

Passage of the Telehealth Modernization Act (S. 3967/H.R. 7623), which was introduced by Senators Tim Scott (R-SC) and Brian Schatz (D-HI) in the Senate, and Representatives Buddy Carter (R-GA), Lisa Blunt Rochester (D-DE), Greg Steube (R-FL), Terri Sewell (D-AL), Mariannette Miller Meeks (R-IA), Jeff Van Drew (R-NJ), and Joe Morelle (D-NY) in the House, is also crucial because in addition to eliminating the originating and geographic restrictions of Medicare coverage for telehealth, it would permanently continue the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated barriers that many patients in rural and underserved areas face when trying to obtain 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.

Permanently removing the antiquated geographic restrictions and the originating site requirements means patients will no longer have to travel, counterintuitively, to a limited set of brick-and mortar medical sites to access virtual care. In an effort to boost access to virtual mental health services, The Connect for Health Act also repeals the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within six months of an initial telehealth visit for a mental health condition.

The integration of this legislation would be a forward-thinking approach to the way health care is delivered, particularly for chronic disease management. These acts collectively aim to dismantle outdated barriers that restrict telehealth's potential to enhance patient care. By permanently removing these restrictions. This is especially important for chronic care management where the need for regular and convenient access to health care services is necessary.

Telemental Health Care Access Act

Federal lawmakers have also introduced stand-alone bills, specifically S. 3651/H.R. 3432/, the Telemental Health Care Access Act, to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within six months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously. The dramatic increase in the availability of telehealth services has catalyzed the development and diffusion of 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. Now, all Americans, including rural, underserved, minoritized and marginalized patients, can receive a combination of in-person and virtual care, which is crucial for patients with chronic diseases. Congress should not permit these flexibilities to expire as it will run counter to its goals of promoting more home-based care.

In closing, the AMA looks forward to working with the Senate Finance Committee to pass the above-mentioned proposals that help promote prevention, the use of telehealth for chronic care management and continuity of care, provides for the solvency of independent physician practices (which form the bedrock of care for rural and underserved communities and our health care system in general), and eliminates the burdens many physician practices face to receive electronic payments for services rendered. The more we can stabilize the Medicare program and reduce the burdens that physician practices face, the more time and resources there are available to dedicate to improving patient care. We stand ready to work with the Committee to improve the Medicare program for the patients struggling with chronic conditions and the physicians who treat them.