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

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

Dear Chairman Wyden and Ranking Member Crapo:

The American Medical Association (AMA) appreciates the opportunity to submit comments in response to the bipartisan Senate Finance Committee paper entitled, "Bolstering Chronic Care through Physician Payment: Current Challenges and Policy Options in Medicare Part B." This paper outlines the Committee's interest in Medicare physician payment reform and improving care for those with chronic illness. The AMA is fully supportive of these efforts to strengthen Medicare and looks forward to collaborating with the Committee to aid in shaping policies ensuring high-quality, sustainable care for current and future generations.

The AMA believes that the fundamental component of any effort to strengthen the Medicare Payment System (MPS) must involve refining the Medicare Physician Fee Schedule (MFS) to more accurately reflect the realities of medical practice today. This includes addressing long-standing issues of payment adequacy and the application of the Medicare Economic Index (MEI) in a manner that ensures that Medicare physician payments keep pace with inflation. The AMA also advocates for a reformed Merit-based Incentive Payment System (MIPS) that reduces the administrative burdens on physicians, allowing them more time to focus on patient care rather than bureaucratic compliance. Equally as important is our emphasis on enhancing Alternative Payment Models (APMs) and value-based care, which incentivize high-quality, coordinated care and are essential for both the efficient management of chronic conditions and the sustainability of our health care payment system over the long term.

Furthermore, the AMA strongly supports the reinstatement of the RVS Update Committee (RUC) relative value unit (RVU) Refinement Panel, which historically provided a fair and transparent appeals process for relative value determinations. To address burden reduction for primary care services, the AMA also recommends emulating the Evaluation and Management (E/M) Workgroup approach by utilizing the Current Procedural Terminology® (CPT®) Editorial Panel and RUC processes.

Finally, 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 calls for additional policies that would further reduce barriers to care and expand access. This includes legislative changes that eliminate cost-sharing for chronic care management services, leveraging the gains made with telehealth flexibilities by continuing these flexibilities, and expanding Medicare coverage to include

prevention efforts for the chronic conditions making the biggest impact on the health of our nation, such as diabetes, and changing how the Congressional Budget Office (CBO) analyzes prevention bills.

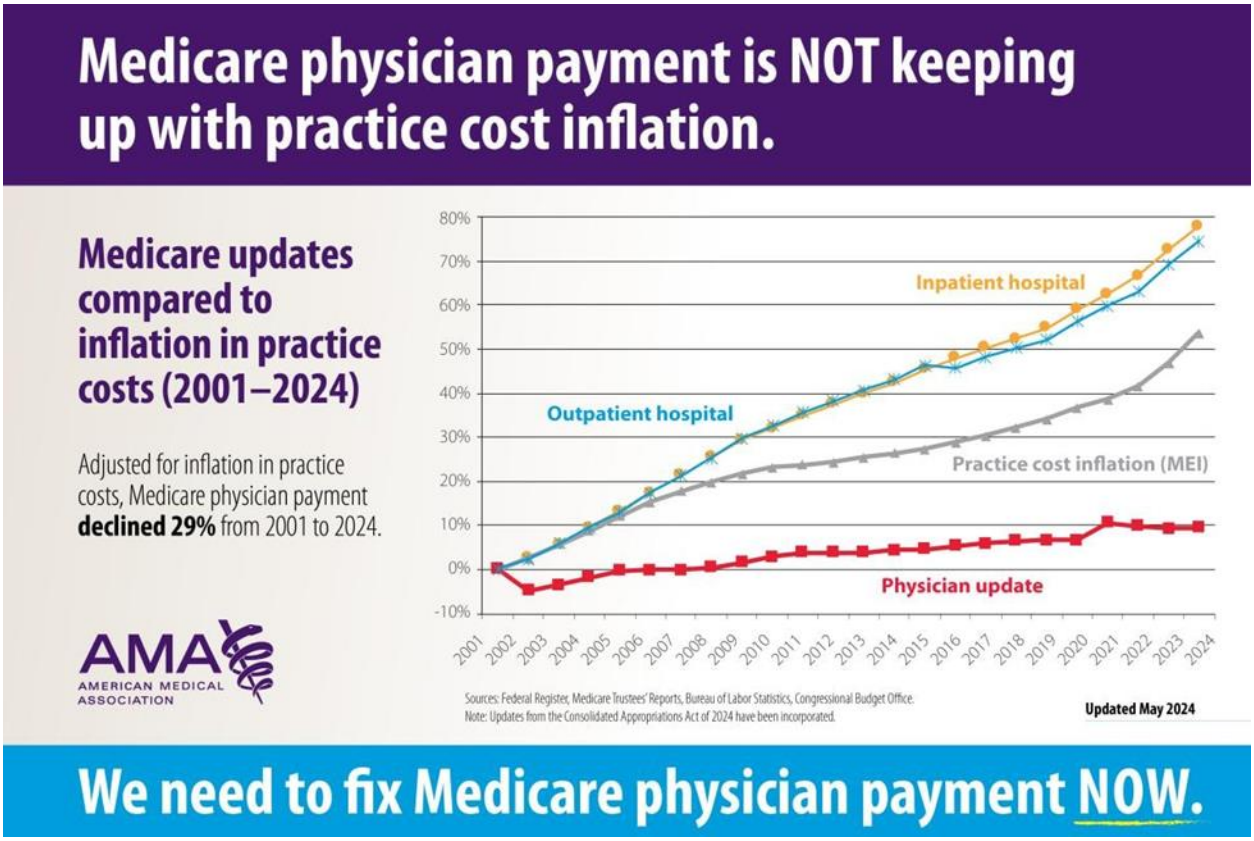
I. ADDRESSING MEDICARE PAYMENT UPDATE ADEQUACY AND SUSTAINABILITY

For services provided to Medicare beneficiaries in the first two months of the year, physicians' payments were cut 3.37 percent under current law. We appreciate Congress for acting to partially mitigate that reduction; however, as of March 9, physicians are still experiencing a Medicare cut of nearly two percent. The impact of the current payment cuts on several services that are both high volume and critical to patient health outcomes, including preventive and primary care services, is shown in the table below. Specifically, the table shows the combined impact of the January 1 through March 8 conversion factor cut of -3.37 percent compared to the March 9 through December 31 conversion factor that offsets the cuts by 1.68 percent for the remainder of the year on these high-volume services.

CPT/ HCPCS Code	**Description**	**Combined Impact for Jan 1- Mar 8, 2024** *(using $32.7442 CF and 2024 RVUs)*	**Combined Impact for Mar 9-Dec 31, 2024** *(using $33.2875 CF and 2024 RVUs)*	**Combined Impact of CY2024 Final Rule and Legislation** *(using 2024 RVUs and Calendar Day Weighted CFs)*
99214	Office/Outpatient Visit Established Patient Moderate MDM 30 Min	-2.0%	-0.4%	**-0.7%**
99233	Subsequent Hospital Inpatient/ Observation Care High MDM 50 Min	-3.4%	-1.8%	**-2.1%**
66984	Cataract Surgery	-2.5%	-0.9%	**-1.2%**
77067	Screening mammography bilateral	-3.8%	-2.3%	**-2.5%**

17110	Destruction benign lesions, up to 14 lesions	-2.8%	-1.2%	**-1.5%**
59400	Obstetrical care	-1.9%	-0.3%	**-0.6%**

At the same time, the cost of practicing medicine, including physician office rent, staff wages, and professional liability insurance premiums as measured by the MEI, is rising at the fastest rate in decades. In fact, the Centers for Medicare & Medicaid Services (CMS) estimated MEI 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.



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 2024, 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 MPS 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 ambulatory surgery centers receive an automatic annual update tied to inflation. As the previous graph shows, Medicare hospital updates rose faster than MEI over the last two decades, while the physician updates stagnated far below their input costs, including rent, wages, and liability insurance premiums. According to data from the Medicare Trustees, Medicare physician pay has increased just nine percent over the last 23 years, or 0.4 percent per year on average. By contrast, Medicare hospital updates totaled over 75 percent between 2001 and 2024, with average annual increases of 2.5 percent for both inpatient and outpatient services. Similarly, the MEI surged by 54 percent between 2001 and 2024, or 1.9 percent per year. As a result, physician pay does not go as far as it used to and increasingly lags the payment rates to hospitals. In fact, when adjusted for inflation in practice costs, Medicare physician payment declined 29 percent from 2001 to 2024, or by 1.5 percent per year on average.

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. Unlike physicians, hospitals and other health care stakeholders benefit from multiple sources of relief during times of high inflation. An often-overlooked byproduct of the multiple federal programs available to other health care stakeholders that help them weather periods of high inflation and payment cuts is its impact on consolidation. A 2023 AMA analysis of changes in the ownership of physician practices over the last decade shows that, by far, the most cited reason that independent physicians sell their practices to hospitals or health systems has to do with payment.[1] Next were the need to better manage payers' regulatory and administrative requirements and the need to improve access to costly resources.[2] The AMA strongly supports policies that promote market competition and patient choice, and payment adequacy is necessary for physicians to continue their 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 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. The AMA has commended the Commission for taking this significant step to stabilize Medicare physician payments. However, we note that implementing an inflation-based update based on only half of the full MEI growth rate, as recommended by MedPAC, 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 in support of half of MEI is insufficient because the practice expense (PE) component of physician payment accounts for approximately half of total Medicare physician payments, and it reflects an incomplete picture of the total cost of running a medical practice. It

[1] These estimates are based on physicians whose practices had been acquired by a hospital or health system after 2012 and who were a practice member at the time of that acquisition.
[2] Other choices included to better compete for employees, to increase availability of additional services that patients need, and to make it easier to participate in risk-based payment models.

is well understood that the PE component does not cover all practice costs. For example, in the 2024 MPS final rule, 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, PE 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.

The AMA greatly appreciates that Congress passed legislation that, once again, mitigated severe Medicare payment cuts. However, these temporary, partial patches exacerbate budgeting challenges for practices making it unsustainable to run an independent practice and divert time and energy that both organized medicine and Congress could be spending pursuing other meaningful health care policies and innovations. Therefore, organized medicine is united in strong 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 give physicians relief from the constant threat of payment cuts, allowing them to plan for the future, invest in their practices, and implement new strategies to provide high-value, patient-centered care. Similarly, CMS can focus on payment policies that advance high-quality care for Medicare beneficiaries and expand access to care without the constant specter of market consolidation.

Addressing Concerns regarding Budget Neutrality in the Medicare Physician Fee Schedule

Another way to help ensure physicians have ample resources to provide care to patients with Medicare is through reforms to statutory budget neutrality requirements within the MFS. By way of background, when certain services are added to the MFS, they are required to be implemented in a budget neutral manner through an across-the-board adjustment to the conversion factor. In most circumstances, CMS can accomplish budget neutrality by looking at the historic utilization patterns for the service. In some cases, however, there is no historic claims data to use in these estimates. Due to this, when it makes a coding change, CMS must predict how often the service will be billed and how much the claims for the service for a year will impact total Medicare payments. When CMS calculates how often a service for which it has no claims history will be utilized in a subsequent year for purposes of making budget neutrality adjustments, it is difficult to make an accurate prediction. On occasion, overestimates of utilization have led to significant budget neutrality reductions in the fee schedule. There is currently no mechanism in place to correct for this, so, when these misestimates are not adjusted in a timely way after claims data on actual utilization become available, the effects of the overestimate are compounded each year, resulting in permanent removal of billions of dollars from the payment pool. Thus, the AMA strongly urges Congress to correct for this by requiring a limited, narrow look-back period related to unbundled codes that receive a utilization estimate so that these analyses can be corrected and the conversion factor prospectively adjusted to reflect actual claims data, preventing the year-over-year compounding effects of the original misestimate.

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. Since then, 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 require that CMS update the key elements of direct practice costs at least every five years so that lengthy delays in these updates do not lead to major payment redistributions when they occur. Finally, 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. Adoption of all of these provisions would bring more stability and predictability to the MPS.

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 took 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.

Reducing Physician Reporting Burden Related to the Merit-based Incentive Payment System

The AMA shares the U.S. Senate Finance Committee's concerns about the administrative burden placed on physicians subjected to MIPS reporting requirements, the program's lack of improvement in patient outcomes and quality of care, and the limited scope of quality measures for specialists. There is also a growing body of evidence that the program is disproportionately harmful to small, rural, and independent practices, as well as practices who care for underserved patients. Finally, MIPS does not provide actionable, timely feedback to physicians to understand their utilization and identify opportunities to reduce avoidable spending for Medicare patients and the program, despite this being required under MACRA.

While CMS has tried to improve the program by introducing the MIPS Value Pathways (MVPs) option, these changes are superficial as the agency believes it does not have statutory authority to remedy the problems identified by the U.S. Senate Finance Committee directly, including awarding cross-category credit to reduce reporting burden. With 46 percent of solo practitioners, 32 percent of small practice practitioners, and 18 percent of rural practitioners receiving a MIPS penalty in 2024, it is clear that the program is broken. Congress must step in and act to prevent unsustainable penalties, particularly on small, rural, and underserved practices and ensure the program works as it was originally intended to improve patient care by ensuring access to timely data; reducing unnecessary administrative burdens; and increasing the clinical relevance of measures to physicians and their patients.

Medicare Physician Data-Driven Performance Payment System

With substantial input from national medical specialty societies and from physicians across the country, the AMA has developed a statutory proposal to replace the flawed MIPS program with a modified program named the Data-Driven Performance Payment System (DPPS). By replacing the current tournament model of payment adjustments with a more sustainable approach tied to annual payment updates, incentivizing CMS to share data with physicians, and improving the underlying measures, DPPS would transform MIPS into the workable program Congress originally envisioned aimed at improving patient care and reducing avoidable costs. Most of the provisions are written to take effect in payment year 2027, which corresponds to performance year 2025. Specifically, DPPS would:

1. *Address Steep Penalties that are Distributed Unevenly*

Following a five-year interruption to the program due to COVID-19 and the Change Healthcare cyberattack, MIPS now subjects physicians to penalties of up to nine percent unless they meet onerous program requirements. Small, rural, and independent practices, along with practices that care for historically minoritized and marginalized patients, are more likely to be penalized, whereas large group practices, integrated systems, and APM participants are more likely to receive bonuses. As noted, **the 2022 Quality Payment Program Experience Report recently showed that 27 percent of small practices, nearly 50 percent of solo practitioners, and 18 percent of rural practices are receiving a MIPS penalty this year. Of those, 13 percent of small practices, 27 percent of solo practitioners, and two percent of rural practices got the maximum negative penalty of nine percent.**

Our proposed DPPS solution would:

- Freeze the performance threshold for at least three years to allow practices to continue to recover from the effects of the COVID-19 pandemic and cyberattack and transition back to MIPS. Importantly, this would also allow CMS time to implement and educate practices on these legislative improvements to the program and for the Government Accountability Office (GAO) to conduct a study about alternative threshold approaches to help ensure the sustainability of the program moving forward.
- Eliminate the unsustainable MIPS win-lose style payment adjustments and instead link each physician's MIPS performance to their own annual payment update (e.g., the percentage increase in MEI or the differential conversion factor updates that go into effect in 2026), creating more alignment across Medicare payment programs such as the Hospital Inpatient Quality Reporting System.
- Reinvest penalties in bonuses for high performers, as well as investments in quality improvement and APM readiness aimed at assisting under-resourced practices with their value-based care transformation. This could be used to help small practices, rural practices, and practices that care for underserved, minoritized, or marginalized patients.

2. *Prioritize Timely and Actionable Data*

Though MACRA requires timely feedback and consultation with stakeholders, there are no enforcement mechanisms to accomplish these provisions. CMS has not met its statutory obligation[3] to provide timely (e.g., quarterly) MIPS feedback reports and Medicare claims data to physicians. Instead, CMS issues a single feedback report after the performance period, up to 18 months after applicable services and care were provided.

Our proposed DPPS solution would:

- Hold CMS accountable for fulfilling its statutory obligations by exempting from DPPS penalties any physicians who do not receive at least three quarterly data reports during the relevant

[3] §42 USC 1395w-4(q)(12) requires the Secretary to provide timely (e.g., quarterly) MIPS quality and resource use feedback, as well as claims data feedback about items and services furnished to patients of a MIPS eligible professional by other providers and suppliers, similar to the types of data provided to Medicare Shared Savings Program accountable care organizations.

performance period. Having these reports during the specific measurement period in question is critical for the program to work as it was intended so that physicians can monitor their ongoing performance and identify gaps or variations in care that can be used to improve quality of care, care outcomes, and reduce costs.

3. *Be More Clinically Relevant and Less Burdensome*

It is extremely burdensome and costly to participate and do well in MIPS. Compliance with MIPS costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related tasks. This high entry barrier is a fundamental reason why less-resourced practices including small, rural, and safety net practices historically do worse in the program. MIPS does not prepare physicians to move to an APM and has not been shown to improve clinical outcomes. Worse, a 2022 study in *JAMA* found MIPS scores are inconsistently related to performance, which "suggests that the MIPS program is approximately as effective as chance at identifying high vs. low performance."

Our proposed DPPS solution would:

- Remove siloes between the four performance categories to maintain accountability while reducing burden. In other words, grant credit to physicians for measures that inherently represent successfully achieving goals across multiple categories. For example, reporting quality data through Certified Electronic Health Record Technology (CEHRT) would result in credit towards the Quality and Promoting Interoperability of CEHRT categories. Participation in a qualifying clinical data registry would automatically count toward fulfilling improvement activities, as well as the Promoting Interoperability category.
- Align program requirements and metrics with other CMS value-based programs to further reduce burden and better align with and support care provided in hospitals and other care settings.
- Recognize the value of clinical data registries and other promising new technologies by allowing physicians to meet the Promoting Interoperability requirements via "yes/no" attestation of using CEHRT or technology that interacts with CEHRT, participation in a clinical data registry, or other similar means.
- Enhance measurement accuracy and clinical relevance, particularly within the cost performance category, to better target variability that is within the physician's ability to influence.
- Provide sufficient opportunity for testing and data collection prior to trying new or substantively revised cost measures by requiring CMS to introduce new or substantively revised cost measures on an information-only basis for at least two years.
- Align cost and quality goals. There is an assumption that MIPS evaluates quality and cost on the same patients and for the same conditions, but this is rarely true. Quality and cost measures are developed in isolation of one another and use different patient populations, attribution methodologies, and risk adjustment methodologies. GAO would report on these gaps and whether harmonizing these measures would better ensure that physicians are being measured accurately on the care they provide, and that Medicare beneficiaries are receiving high-value care.
- Improve quality measurement accuracy by incentivizing physicians to test new or significantly revised measures, including Qualified Clinical Data Registry measures, or measures reported using a MIPS collection type (e.g., electronic clinical quality measures) that are being used by a

particular physician, group, or Accountable Care Organization (ACO), for the first time, by awarding pay-for-reporting credit for three years.

The following is a chart that compares the status quo under MIPS with the proposed reforms in the DPPS discussion draft. A copy of the discussion draft, as well as a redline of statute, are included in our response as separate documents. Corresponding references to both documents are included throughout the chart.

	MIPS	Data-Driven Performance Payment System (DPPS)
Performance threshold	The performance threshold is set at the mean or median. Physicians who score between zero points and the performance threshold are penalized, while physicians who score between the performance threshold and 100 points receive a bonus. In 2024, the performance threshold is 75 points.	Congress would freeze the performance threshold at 60 points for the 2025, 2026, and 2027 performance periods while physicians recover from the COVID-19 pandemic, Change Healthcare cyberattack, and CMS implements legislative improvements to the program. This is consistent with the 2021 performance threshold, which was set based on the transitional policies of MIPS and should continue to apply as the program remains in flux following a 5-year interruption due to COVID-19 and subsequent disruption by the cyberattack. There is an option for the Secretary to extend the performance threshold freeze at 60 points beyond the 2027 performance period. For the 2028, 2029, and 2030 performance periods (or, if the Secretary extends the period of the freeze at 60 points, for the three years following the last year of such extension), the Secretary shall gradually and incrementally increase the threshold before transitioning to the mean or median. Discussion Draft: Page 2, line 14 through page 3, line 5. Redline: Bottom of page 11 through page 12
Threshold reform	Not applicable	GAO must submit a report to Congress and the HHS Secretary in consultation with physician organizations by the end of 2029 which includes detailed recommendations for establishing a replacement performance threshold. If legislation is not enacted to establish a replacement performance threshold within three years from the date of the enactment of the DPPS Act, the Secretary is required to promulgate final regulations establishing a replacement performance threshold based on the GAO recommendations.

		Discussion Draft: Page 3, lines 6 through 30 Redline: Bottom of page 12 through middle of page 13
Payment adjustments	MIPS adjusts physicians' Medicare payments upward or downward by extremely wide margins, ranging from -9 percent to a hypothetical +27 percent. Under MACRA, MIPS payment adjustments apply to the physicians' paid amount. For example, in 2024, we understand the maximum increase is 8.25 percent and the maximum decrease is -9 percent, which apply on top of the conversion factor cuts that stem largely from budget neutrality requirements.	While budget neutrality would be preserved, DPPS would repeal the tournament model. Instead, payment adjustments would be applied as a percentage to the annual payment update (e.g., 0.25 percent beginning in 2026 under current law or the increase in MEI under HR 2474). The payment adjustments would apply as follows: • Physicians who score above the performance threshold would receive an increase of one-quarter of the update. • Physicians who score at the performance threshold would receive the annual update. • Physicians who participate but receive a score below the threshold receive a penalty equivalent to one-quarter of the update. • Physicians who do not participate would receive a penalty equivalent to one-half of the update. • A floor of zero would prevent DPPS payment adjustments from imposing negative updates. • The adjustment would not be applied in a year for which the update to the conversion factor is negative. These updates are for one year only. To illustrate, assume physicians will receive an update tied to inflation in 2027 and the update is two percent. Physicians who score above the performance threshold would receive 2.5 percent. Physicians who score at the performance threshold would receive a two percent update. Physicians who participate in MIPS but score below the threshold would receive a 1.5 percent update. Physicians who do not submit any MIPS data would receive a one percent update. All physicians would receive a positive update unlike under current law. As another example, under current law, the update in 2027 is 0.25 percent. Physicians who score above the performance threshold would receive a 0.3125 percent update. Physicians who score at the

		performance threshold would receive a 0.25 percent update. Physicians who participate in MIPS but score below the update would receive a 0.1875 percent update. Physicians who do not submit any MIPS data would receive a 0.125 percent update. All physicians would receive a positive update unlike under current law. Finally, in this example, under current law the update in 2025 is zero percent. In this scenario, all physicians would receive a zero percent update regardless of their performance in MIPS. Discussion Draft: Page 4, line 1 through page 6, line 21; budget neutrality is on page 6, line 22 through 7, line 19. Redline: • Update to conversion factor conforming amendment on the top of page 1 • MIPS payments start on the middle of page 10 through page 11 • Application of adjustment factors starts on the bottom of page 13 through the top of page 15 • Budget neutrality is on page 15
Improvement Fund	Bonuses are paid based exclusively on MIPS performance. The Small, Underserved, and Rural Support technical assistance program ended in 2022 due to lack of funding. It had previously provided support for small practices (fewer than 15 clinicians) and practices in rural locations, health professional shortage areas, or medically underserved areas.	DPPS penalties would fund bonuses to MIPS participants that perform well in DPPS, as well as a new fund for improvement and investments in value-based care, such as data analytic capabilities. CMS would make grants to small, rural, underserved practices and practices with low composite scores for these value-based care funds. Importantly, these investments would also help practices transition to APMs. Discussion Draft: Page 7, line 20 through page 8, line 13 Redline: Page 16
Timely and Actionable Feedback and Data	Despite statutory requirements that CMS provide timely MIPS and claims data, physicians received their most recent MIPS Feedback Report, based on 2022 performance, in August 2023. No physician in MIPS has ever received	Physicians who do not receive quarterly feedback reports on administrative claims-based quality and cost measures would be exempt from any DPPS penalty (i.e., any amount below the annual update). Discussion Draft: Page 8, line 20 through page 9, line 22 Redline: Page 17

	Medicare claims data similar to what Medicare Shared Savings Program ACOs receive, which includes Medicare Parts A, B, and D claims data for their assigned beneficiaries. 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.	
Multi-category credit	MIPS performance is measured across four categories – quality, improvement activities, promoting interoperability (health IT use), and cost. Each category has disparate measures, scoring rules, and attribution methods. CMS has informed the AMA that their Office of General Counsel interprets the statute as requiring data submissions in each category, thus preventing automatic or seamless multi-category credit.	CMS would be required to give automatic credit in each applicable performance category for a measure or activity that satisfies multiple performance category requirements as determined via rulemaking. If a MIPS eligible professional does not report on such a measure or activity for a performance category and automatic application of the measure for that performance category would result in a lower performance score for the professional, then the Secretary would not automatically apply such measure or activity for that performance category. Discussion Draft: Page 9, line 25 through page 11, line 2 Redline: Top of page 4 and bottom of page 8 through top of page 9
Expansion of Facility-based Scoring	Certain MIPS eligible clinicians receive their facility's Hospital Value-Based Purchasing (VBP) Program score for the quality and cost categories without submitting any additional quality measures. To qualify,	This bill would allow the Secretary to expand the existing facility-based scoring option by applying scores from hospital outpatient department and other care setting value-based payment programs to all four DPPS categories. Further, CMS would expand the facility-based scoring option to physicians who furnish 50 percent of their services in facility

	physicians must furnish 75 percent or more of their services in a hospital setting (POS codes 21, 22, or 23), bill at least one service in an inpatient hospital or emergency department, and their facility participates in the VBP Program. For groups, 75 percent of the clinicians billing under the TIN must meet the definition of facility-based.	settings other than the hospital, including ASCs, inpatient psychiatric facilities, and SNFs. Similarly, for groups, 50 percent of clinicians in the group must meet the definition of facility based. Discussion Draft: Page 11, line 3 through page 13, line 10 Redline: Bottom of page 3 and the subparagraph (K) beginning on page 9
Clinical data registries and innovative health IT	Despite clinical data registries' proven ability to meaningfully improve patient care and numerous statutory obligations to promote and incentivize the use of clinical data registries, CMS has created numerous obstacles for clinical data registries to succeed within the program and has limited the ability of physicians to leverage their participation in these quality improvement efforts for MIPS. Further, highly prescriptive measures in the PI (health IT) category restrict the program's ability to grow with new technological innovations that drive the industry forward.	CMS would be required to treat physicians who attest to reporting quality measures via clinical data registries as automatically satisfying the requirements of the Promoting Interoperability and Improvement Activities categories. Further, the requirements for the Promoting Interoperability category would be met via "yes/no" attestation of using CEHRT or interacting technology products, participation in a clinical data registry, or other less burdensome means. Discussion Draft: • Amendments to PI category under MIPS – page 13, lines 13-26 plus hospital-based eligible professionals clarification on page 13, line 27 through page 14, line 11 • Amendments to meaningful use determination criteria – page 14, line 12 through page 15, line 9 • Amendments to Qualifying (and partial-qualifying) APM participant criteria – page 15, lines 10 through 21 • Amendments to MSSP – page 15, lines 22 through 31 • Amendments to clinical practice improvement activities – page 16, lines 1-9 Redline: • Amendments to PI category under MIPS – bottom of page 5 to top of page 6, plus hospital-based eligible professionals clarification on page 6 (the clause (iii) 1/3 from top of page) • Amendments to meaningful use determination criteria – pages 1-2

		• Amendments to Qualifying (and partial-qualifying) APM participant criteria – Top of page 24 • Amendments to MSSP – Bottom of page 24 • Amendments to clinical practice improvement activities – The clause (iv) on the middle of page 7
Cost measures	CMS continues to use the total per capita cost measure that holds physicians accountable for costs outside of their control. Additionally, CMS develops new episode-based cost measures around costly Medicare conditions despite concerns about access to care (e.g., psychoses) in order to meet statutorily imposed requirement that cost measures must account for at least one-half of Medicare Part A and B expenditures. This forces CMS to develop measures based on volume, rather than based on opportunities to reduce variations in care and produce savings in Medicare. Finally, CMS does not have the authority to test new cost measures before they are used to impact physician payment.	By eliminating the requirement that CMS must account for at least one-half of all Parts A and B expenditures with its cost measures and affording CMS the ability to test new cost measures, CMS could significantly improve the cost category by developing and validating measures that have a potential high impact for change at the physician level. In addition, the requirement to measure total Parts A and B costs would be eliminated. • Discussion Draft: Page 16, lines 10-20 • Redline: Pages 19-21 Finally, new and substantively revised cost measures would be informational only for a minimum of two years. Physicians would receive quarterly feedback reports as required above. CMS would be required to provide for a public comment period on the measures that allows for MIPS eligible professionals who are commenters, as applicable, to take into consideration the information they received during the informational period. Then for the measures to be included for assessment and scoring purposes, CMS would propose the measures for inclusion through rulemaking. • Discussion Draft: Page 16, line 21 through page 17, line 26 • Redline: Bottom of page 7, through ¾ of page 8
Cost and quality measure alignment	MIPS cost and quality measures are not aligned and typically do not reflect the same care provided to the same patients. Physicians may be penalized for providing preventive services, which are important for high quality care, under the Total Per Capita Cost measure, which is a blunt summation of all Medicare Parts A and B spending by a beneficiary	GAO would be required to submit a report to Congress and the HHS Secretary within 12 months of passage of the bill about whether this program incentivizes lower quality to achieve lower costs. Specifically, the study calls for identification of the misalignments, gaps, and other potential causes for such incentives, including that the cost measures are not aligned with the quality measures (e.g., not corresponding to the same conditions or episodes, not applying to the same timeframes, not applying to the same physicians, or not applying to the same panel of patients). GAO would provide

	during a year. While CMS believes MVPs will solve this issue, they are merely a repackaging of existing measures and do not get at the root cause.	recommendations for modifications to eliminate these gaps or misalignments and would identify whether the changes require legislation or regulation. Discussion Draft: Page 17, line 27 through page 18, line 18
Quality measures	Investing in new quality measures is extremely costly and time-consuming. Worse, there are disincentives for physicians to use new quality measures in MIPS as they are likely to be scored worse than existing measures with a benchmark. Physicians are inherently taking a risk when reporting any new measure, which hinders the program's ability to continue to grow and adapt into the future.	CMS would be required to incentivize reporting of new and substantively revised quality measures, as well as quality measures without a benchmark and MIPS quality measure collection types that are being used by a physician for the first time, by treating them as pay-for-reporting for three years. In other words, physicians who meet the reporting criteria would automatically receive full credit (e.g., 10 points) for that measure for three years. Discussion Draft: Page 18, line 19 through page 19, line 18 Redline: See paragraph (5)(B)(i) on the middle of page 5 and the new clause (iv) beginning on middle of page 6 through top of page 7

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

Incentivizing Participation in Alternative Payment Models

The AMA supports S. 3503/H.R. 5013, the "Value in Health Care (VALUE) Act." This important bipartisan legislation would reinstate and extend the five percent bonus for participating in APMs and maintain the 50 percent revenue-based threshold for two years. This bipartisan legislation would help ensure that physicians in communities across the country have the financial assistance they need to transition to and participate in APMs, especially those that require upfront and operating cost investments and downside financial risk.

The AMA also urges Congress to support development of a more robust pipeline of APMs that would be available to all types of physicians in all geographic locations in the country. For over a decade, the AMA has advocated for the creation of APMs that would enable physicians to deliver better care to their patients at a lower cost to the Medicare program. We strongly supported passage of the provisions in MACRA that were designed to facilitate the creation of physician focused APMs, organized numerous educational programs about APMs that were attended by hundreds of physicians, and provided technical assistance to medical societies so they could play an active role in developing successful APMs. We are disappointed that, nearly 10 years after the passage of MACRA and even longer since the creation of the Center for Medicare and Medicaid Innovation (CMMI), most physicians still do not have the opportunity to participate in an APM that is designed for the kinds of patients they treat or is available in their region, leaving them shut out of benefitting from the APM bonus payments that Congress created in MACRA.

This problem is especially acute for non-primary care specialists for which there are extremely limited offerings despite repeated attempts by the AMA calling on CMMI to develop APMs for specialists, including the Payments for Accountable Specialty Care approach.

Physicians have made it clear that they *want* to participate in well-designed APMs that will enable them to deliver better care to their patients. Unfortunately, the vast majority of models to date have taken a short-sighted approach, forcing practices to enter into steep downside risk arrangements with little up-front funding support. They also fail to correct for chronic under-investments in preventive care, care coordination, and other high-value services. As a result, many physician practices struggle with the significant costs that are required up front in making the transition to APMs. Up until now, physicians have had to structure their practices to survive under traditional Medicare fee-for-service payments. A well-designed APM should allow them to restructure the way they staff their practices and design clinical workflows to deliver better care to patients. However, this transition requires time, training, and investment, which can often cause temporary financial losses. The APM bonus payments are needed to offset these transition costs. With so many physicians, particularly specialists, not yet having an opportunity to participate in APMs, our work is far from over. Cutting this critical support now will significantly undercut the important progress at a critical inflection point.

Unfortunately, most of the APMs created by CMMI to date have been designed primarily to cut Medicare spending and shift financial risk to physicians and hospitals, not to give physicians the resources and flexibility they need to improve care for patients. A 2021 article written by AMA Immediate Past President, Jack Resneck Jr., MD, explained some of the many problems with CMMI APMs and why they have failed to provide what physicians need to deliver higher-value care. A study by the GAO conducted the same year found that physicians in rural and underserved communities faced particular challenges in participating in the APMs created by CMMI. However, the APMs available in 2024 have essentially the same structure as those available when that article and study were written.

When Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), we were hopeful that this would result in the creation of better APMs that would help physicians deliver higher-quality care to their patients. Many frontline physicians who had experienced barriers to value-based care in their practices spent many hours to develop proposals for patient-centered APMs that could offer meaningful benefits to patients and savings for the Medicare program.[4] The PTAC ultimately recommended more than a dozen of these physician-designed, patient-centered APMs. However, **to date, not a single one of these models has been implemented or even tested by CMMI.** Two leading members of the PTAC resigned several years ago, saying it had become clear to them that CMS had no intention of ever implementing any APM recommended by PTAC.

The low rate of physician participation in APMs is not due to the unwillingness of physicians to give up traditional fee-for-service payment, but the fact that to this point, CMMI has designed APMs that do not support better patient care and that instead are focused on putting physicians at excessive financial risk. Rather than working with physicians to design and implement better APMs, we are very concerned that CMMI now simply wants to mandate that physicians participate in the problematic models it has created.

CMMI has also led Congress and others to believe that the only way to design APMs is through the type of complex shared savings/shared risk models they have created so far. However, this is untrue. There are

[4] See examples at https://www.ama-assn.org/practice-management/payment-delivery-models/medicare-alternative-payment-models.

better ways to design APMs, as shown in the Guide to Physician-Focused Payment Models that was developed by the AMA nearly a decade ago. Because there is not one type of APM that will work for every physician, the report describes seven different types of APMs. Some would support high-quality longitudinal care of chronic conditions, while others would support high-quality acute care. CMMI has not implemented any of the approaches described in this report, which is a major reason why so few physicians, particularly specialists, have been able to participate in APMs.

As the Senate Finance Committee considers possible statutory changes to help spur the development and growth of APMs, the AMA recommends that it seek to obtain information regarding physicians' experiences with CMMI APMs, what they believe could be accomplished with better-designed APMs, and what could be done to accelerate the transition to more effective APMs. For example, the Committee could call for an independent study of:

- The proportion of physicians in each specialty and state who are participating in current CMMI APMs;
- The reasons that physicians are not participating in the APMs that have been created by CMMI;
- The changes physicians would like to make in the way they deliver care that would both improve outcomes for patients and reduce Medicare spending, and the barriers that current Medicare payment systems create to delivering services in these ways;
- How physicians believe CMMI APMs should be designed to more effectively support their ability to improve care for patients and reduce Medicare spending; and
- What short-term financial and technical assistance do physicians need to be able to make the transition to a well-designed APM.

To our knowledge, CMMI has not publicly shared information about these issues, despite the obvious benefit it would have for designing better APMs and increasing the participation of physicians in APMs. CMMI also operates largely in isolation as it develops new APM concepts, resulting in the above-described shortcomings.

In addition, we recommend the study include gathering information from the physicians who developed the APM proposals that were recommended by PTAC to learn:

- Why they believed their proposal would better support higher-value care than the existing APMs;
- The challenges they faced developing their proposal and their feedback on their experience with the PTAC process;
- Whether CMMI contacted them to learn more about their proposed APM or to try and resolve any concerns about it;
- Whether the physicians received any explanation as to why their proposal would not be implemented; and
- Whether they still believe the proposal they developed should still be implemented by CMMI.

II. ENSURING THE INTEGRITY OF THE MEDICARE PHYSICIAN PAYMENT SCHEDULE

Reinstatement of the RVS Update Committee Refinement Panel Process

The RUC is a private organization bringing together clinical experts from more than 100 national medical specialty societies and other health care organizations to provide information on the resource costs required to care for patients. Since 1992, the RUC has shared data and recommendations publicly, utilizing the established rules developed and maintained by CMS. CMS staff attend the RUC meetings as observers and then consider the committee's resource cost recommendations, along with other data, to propose RVUs, an important part of the Resource-Based Relative Value Scale (RBRVS) and MFS. The information from the RUC is credible and essential to ensuring the integrity of the RBRVS.

Congress requires that CMS provide the ability for public comment and re-examination of the resource costs required to provide individual services at least every five years. In the first 15 years of the RBRVS, CMS accomplished this requirement by seeking public comment on potentially misvalued services. CMS received few comments on potential overvaluations, even after it engaged in a national effort to seek feedback from private insurers and other stakeholders and provided for an expansion of the comment period. In response, the RUC created a Relativity Assessment Workgroup to develop objective screens to annually identify services for re-review. Over the past 18 years, this effort has resulted in RVU reductions or elimination of 1,600 CPT codes, resulting in over $5 billion in annual redistribution within the MFS. The RUC's efforts are dependent on monitoring claims data. Currently, only the traditional Medicare claims data are publicly available in a usable format for the RUC. It would improve the RUC process to ensure the broader availability of Medicare Advantage and Medicaid data.

The RUC has a long history of recommending improvements to primary care payment, including increases in E/M services each year they were nominated for review by the national organizations representing primary care physicians (1997, 2007, 2021). The RUC, working with the CPT Editorial Panel, ensured appropriate valuation and payment for immunization services, care coordination, and preventive visits—all services commonly performed by primary care physicians.

In 2016, CMS permanently eliminated its Refinement Panel process by making the nomination requirements so specific that no services could be eligible going forward. At that time, CMS designated the Refinement Panel only to review Interim Final values and simultaneously discontinued the concept of Interim Final values beyond calendar year (CY) 2016. In the CY 2016 Proposed Rule, CMS stated their belief that since proposed work RVUs will now be published, the Refinement Panel process will no longer be necessary. The Agency had asserted that the opportunity for stakeholders to provide comments on codes in both the Proposed and Final Rules "…will allow a better mechanism and ample opportunity for providing any additional data for our consideration, and discussing any concerns with our interim final values, than the current refinement process." While the change to including proposed work RVUs in each year's Notice of Proposed Rulemaking continues to be strongly supported by the AMA, we do not agree that these process changes have made the Refinement Panel process obsolete. These separate processes are not mutually exclusive and could be undertaken in tandem to provide stakeholders with multiple avenues of appeal.

For two decades, the CMS Refinement Panel Process, comprised of medical officers from the Medicare carriers, was considered by stakeholders to be a fair appeals process and CMS deferred to the vote conducted by the Refinement Panel in finalizing values. In the last few years of the Refinement Panel's

existence, CMS modified the process to only consider codes for which new clinical information was provided in the comment letter. CMS also began to independently review each of the Refinement Panel decisions in determining which values to finalize. In many cases, the Refinement Panel supported the original RUC recommendation and the commenter's request, yet CMS chose instead to implement CMS' original proposed modified value. The complete elimination of the Refinement Panel discontinued CMS' reliance on outside stakeholders to provide accountability through a transparent appeals process.

The following recommendation was previously made to CMS by the AMA and 89 national medical organizations on August 23, 2016: **The AMA urges CMS to reestablish the Refinement Panel process to create an objective, transparent, and consistently applied formal appeals process, that would be open to any commenting organization, and provide stakeholders with an avenue to appeal.** The original Refinement Panel process, coupled with the input from the RUC, would provide the best mechanism to utilize the expertise from physicians and other health care professionals to determine the resources utilized in the provision of a service to a patient.

Finally, the RUC's work and expertise ultimately provides an important data set to CMS without any tax-payer expenditure. Legislative efforts to recreate the RUC within CMS are duplicative and inefficient, as well as an unnecessary use of scarce federal resources. Moreover, **the AMA strongly believes that physician input is essential to identifying the valuation of physician services, and reliance on third-party entities risks losing vital input from physicians about the procedures and care that they provide.**

III. IMPROVING CHRONIC CARE THROUGH LEGISLATION

Increasing Access to Chronic Care Management Services

The AMA supports H.R. 2829, the "Chronic Care Management Improvement Act of 2023," which is an important avenue for enhancing chronic disease management (CCM) within the Medicare program. This legislation, aimed at eliminating patient cost-sharing for 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 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, 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.

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 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 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 S. 4904/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.

<u>Hybrid Per-Beneficiary Per Month Payment for Primary Care Services</u>

As discussed above, we do not believe payment adequacy for any physician, including primary care physicians, can be achieved without allocating additional funds to support appropriate and sustainable

payments for physician services, including an annual inflation update based on the MEI. Annual updates are essential to ensure the viability of independent practice, including primary care practices, and patient choice of care setting.

In addition, this paper discusses the burdens of coding certain services within the Medicare physician payment schedule, particularly services provided by primary care physicians. We support these goals and a number of mechanisms have been employed in the past to reduce the burden on primary care physicians. For instance, the impetus behind the E/M coding overhaul, which began with the office and outpatient code family in 2021 and expanded to other code families in 2023, was to reduce documentation and "note bloat" across all specialties and sites of service. Burden reduction was accomplished through several coding guidelines and CMS policy changes, including:

- CMS eliminated the requirement that physicians re-record elements of history and physical exams when there is evidence that the information has been reviewed and updated;
- The updated guidelines simplified code selection criteria and made them more clinically relevant and intuitive by allowing selection based on time or medical decision-making; and
- The updated guidelines created consistency across payers by adding detail within the CPT E/M guidelines and aligning Medicare and CPT requirements.

These changes were embraced by the physician community, including the American Academy of Family Physicians and American College of Physicians, as reducing unnecessary documentation burden. For example, the new framework includes CPT code descriptor times, revises interpretive guidelines for levels of medical decision-making, and permits choice of medical decision-making or time to select code level.

To achieve these significant reductions in burden in E/M coding guidelines, the AMA convened an E/M Work Group that included members of both the RUC and CPT Editorial Panel and held numerous meetings that were attended by hundreds of physicians representing all interested national medical specialty societies, as well as CMS staff. Physician input and clinical expertise were necessary to reach consensus across medicine and accomplish the goal of modernizing E/M coding guidelines. **As we understand that burden reduction for other primary care services is one of the Senate Finance Committee's goals with this bundled payment model, we believe the best approach would be to emulate the E/M Work Group, by going through the CPT Editorial Panel and RUC process to create an appropriate bundled payment for primary care services that reduces burden. We also believe this approach would safeguard against inappropriate bundling of CPT codes by Medicare and other health plans that follow Medicare's lead, which could lead to insurers not recognizing separate billing for certain services, such as increased time in screening, counseling, and treatment for health-related social needs or co-morbid conditions that increase risk of morbidity or mortality.**

Finally, we emphasize that any new approach to increase payment for primary care services should be outside of the budget neutrality parameters in Medicare. Physicians across-the-board have absorbed a nearly two percent reduction to the conversion factor this year, on top of a nearly two percent reduction last year, which followed cuts of -0.8 percent and -3.3 percent in 2022 and 2021. These cuts stem from budget neutrality reductions, and Congress has had to step in for the past four years to mitigate their severe impact on physician practices, who are simultaneously facing inflationary pressures across their costs. Another round of budget neutrality cuts would not be sustainable and would move physician

payment farther away from covering the costs to provide services to America's seniors and persons with disabilities.

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" (S. 3967/H.R. 7623), there is a pathway for permanency of the advances made in telehealth accessibility, particularly vital for patients managing chronic conditions.

The AMA also supports H.R. 8261, the "Preserving Telehealth, Hospital, and Ambulance Access Act" as an interim step. This important legislation will extend through 2026 many of the above telehealth provisions we strongly support including audio-only telehealth services, exemptions to geographic and originating site restrictions, and delaying the in-person requirements for telemental health services. This bill also extends the Acute Hospital at Home Waiver Flexibilities through 2029. Although our ultimate goal is that these flexibilities are made permanent to facilitate greater long-term investment in virtual care for the betterment of patients. We are glad Congress is prioritizing legislative action to extend the telehealth services and we urge the Senate to pass companion legislation to extend important telehealth provisions currently scheduled to lapse at the end of the year.

The AMA appreciates the Senate Finance Committee releasing this paper and engaging in a meaningful exploration of physician payment issues. Our physician and medical student members stand ready and eager to work with you on developing and enacting long-term, permanent solutions to these problems that have negatively impacted the American health care delivery system for decades.

Sincerely,

James L. Madara, MD