STATEMENT

of the

American Medical Association

U.S. House of Representatives

Committee on Ways and Means

Re: Enhancing Access to Care at Home in Rural and Underserved Communities

March 26, 2024

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The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House Committee on Ways and Means as part of the hearing entitled, "Enhancing Access to Care at Home in Rural and Underserved Communities." The AMA commends the Committee for its consideration of this critically important issue aimed at, among other things, ensuring the continuation of certain programs and policy flexibilities granted as part of the response to the COVID-19 pandemic that help ensure patients retain access to at-home care. The COVID-19 pandemic made clear that rural and underserved areas that have historically lacked adequate access to health care services can greatly benefit from permanent legislative and regulatory flexibilities. As a result, we applaud the Committee for recognizing the importance of promoting health equity as it considers which COVID-19 policies to retain to facilitate continued access to home-based care. In addition, we urge Congress to consider how making many of these existing flexibilities permanent will provide the necessary assurances that physicians, health care organizations, and patients may need before investing additional resources into policies such as telehealth and the Hospital at Home program. Long-term or permanent extensions of policies that promote and enable at-home care will bring further value to the American health care system.

INNOVATION MODELS AND TECHNOLOGY

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services for Medicare patients by passing the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/H.R. 4189) and H.R. 7623, the Telehealth Modernization Act.

Introduced by Representatives Mike Thompson (D-CA) and David Schweikert (R-AZ) on the Ways and Means Committee, 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. Therefore, 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 Reps. 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 crucial because it permanently continues 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 modifying 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. Federal lawmakers have also introduced stand-alone bills, specifically H.R. 3432/S. 3651, 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.

The AMA also strongly opposes any efforts to impose other types of antiquated "guardrails" pertaining to telehealth services. The AMA views telehealth as a method to deliver care, and creating significant burdens to access these services in the name of program integrity requires substantial justification. As a result, the AMA strongly opposes H.R. 1746, the Preventing Medicare Telefraud Act, or any other legislation that promotes similar policies.

This legislation requires a patient to receive an in-person visit within 6 months of receiving "high-cost" durable medical equipment (DME) and laboratory tests ordered via telehealth. This provision makes little sense as it is impossible clinically for a physician to know if the patient will need high-cost DME or laboratory tests prior to receiving a telehealth visit. Under this legislation, "high cost" DME and

laboratory tests would also be defined by the Centers for Medicare & Medicaid Services (CMS) Administrator, which the AMA believes to be an excessive expansion of executive authority.

In addition, H.R. 1746 stipulates that, beginning six months after the effective date of the high-cost DME/lab clause, Medicare Administrative Contractors (MACs) shall conduct reviews on a schedule determined by the HHS Secretary of all claims of high cost DME/lab tests ordered over the preceding 12 months when at least 90 percent of these services are prescribed by a physician/provider via telehealth. Again, since telehealth is simply a modality, the AMA believes such audits are not appropriate or necessary because it provides no consideration of medical necessity. Additionally, the percentage threshold could lead to some very odd results that could disproportionately impact smaller practices. Policymakers should consider a small practice only ordering nine out of 10 total "high cost" DME/Labs via telehealth. Under this bill's provisions, this would still trigger an automatic audit, which is excessive and unnecessarily burdensome.

In general, the AMA urges members of the Ways and Means Committee to reject any inclination to establish additional guardrails, including in-person visits or mandatory audits, in the name of rooting out fraud, waste, and abuse. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication of services are of particular concern for telehealth services.

The AMA believes existing HHS and OIG fraud capabilities and authorities are more than adequate to police telehealth services in the same way they oversee in-person Medicare services. A February 2024 HHS OIG report confirms this reality.[1] For 105 out of the 110 sampled Evaluation and Management (E/M) services provided via telehealth during the early parts of the pandemic, providers appropriately complied with Medicare requirements. As a result, OIG did not provide any policy recommendations to CMS because, "…providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Medicare fraud is still Medicare fraud, irrespective of whether it involved telehealth services. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare & Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

In February 2021, HHS's Principal Deputy Inspector General (OIG) released a statement dispelling any concerns with OIG's authority or ability to address concerns of fraud and abuse. Instead, HHS OIG's statement highlights concerns stem from "telefraud" schemes, rather than "telehealth fraud," in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the telehealth visit but instead use the sham telehealth visit to induce a patient to agree to receive unneeded items and gather their info. In other words, whether the telehealth service itself is covered has no impact on these kinds of fraudulent schemes.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. CMS has also implemented Place of Service

[1] https://oig.hhs.gov/oas/reports/region1/12100501.asp.

(POS) indicators for this purpose, including POS 02 when the originating site is someplace other than the patient's home and POS 10 when the patient is in their home. Additional indicators may be used for asynchronous services and home health services provided via telehealth. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via Modifier 95 and other CMS indicators. The Modifier 95 describes "synchronous telemedicine services rendered via a real time Interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. Modifier 95 and the POS indicators are applicable for telemedicine services rendered through December 31, 2024. The requirement to code with Modifier 95 and POS enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

Acute Hospital Care at Home Waiver Program Extension

In addition to telehealth, the Ways and Means Committee should consider extending flexibilities that permit the continuation of the hospital-at-home program. On March 11, 2023, the AMA along with other organizations, including medical groups participating in the Acute Hospital Care at Home (AHCaH) waiver program, submitted a request to Congress asking for at least a five-year extension of AHCaH before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to AHCaH programs that have demonstrated excellent clinical outcomes and lower the costs of care. With an expiration set for the end of this year, medical groups and health systems nationwide need assurance that this waiver program will be extended if they are going to invest their resources into logistics, supply chain, and workforce for AHCaH. A five-year extension can also help ensure hospital inpatient unit care is available for the patients who need it while enabling patients who can and want to be treated in their home to have the opportunity to do so, creating needed capacity for hospitals without increasing health system costs.

The State of Health at Home Models: Key Considerations and Opportunities

Building on existing playbooks and resources supporting digitally enabled care, the American Medical Association conducted research to explore the different ways health care is and can be provided in the home. The AMA report titled, "The State of Health at Home Models: Key Considerations and Opportunities" offers a comprehensive guide that outlines the concept and benefits of delivering care to patients in their home environments.[2] These include recommendations to:

- Determine whether your practice or organization should build your health at home program internally or partner with another organization.
- Consider required training to strengthen your mobile workforce, which is a core component of health at home programs.
- Ensure you understand the unique and varied circumstances of each home environment and plan for the patient and caregiver experience in detail.
- Develop the infrastructure up front that will provide the necessary tools to appropriately handle the flow of resources and information to provide patient care as required by your specific program.

[2] https://www.ama-assn.org/system/files/health-at-home-models.pdf.

Future of Health Case Study: Atrium Health

This case study highlights how this vision is being accomplished through a strategic partnership between a traditional brick-and-mortar health system and a technology company, with a common goal to build and scale a program that enables patients to continue their care and recovery at home. Each organization brings its expertise to the partnership, enabling thoughtful development and implementation of a complex, digitally enabled clinical initiative.

Payment and Delivery in Rural Hospitals

In this issue brief, the AMA reports on background, challenges, costs and strategies related to the delivery of care in rural hospitals. Additionally, this includes strategies to improve rural health and hospital viability.

ASPE Report - Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019-2021

This report by the Assistant Secretary for Planning and Evaluation (ASPE) reveals sustained above-pre-pandemic levels of telehealth utilization among Medicare beneficiaries, notably for behavioral health and primary care visits. This sustained utilization highlights the importance of telehealth in bridging access gaps, particularly for vulnerable populations due to the severity and complexity of their illnesses. The findings from ASPE highlight the critical role of telehealth in maintaining continuity of care and suggest a pressing need for policies that support the permanent integration of telehealth services within the Medicare program.

AHRQ Study - The Impact of Expanded Telehealth Availability on Primary Caree Utilization

An Agency for Health Care Research and Quality (AHRQ) funded study analyzing over four million primary care encounters highlights telehealth's role in maintaining health care utilization levels without contributing to overutilization. This study's results challenge concerns about potential increased health care utilization due to telehealth expansion, reinforcing telehealth's value as a viable alternative to in-person encounters when deemed appropriate. Given these insights, it is important for legislation like the CONNECT for Health Act and the Telehealth Modernization Act to pass, ensuring telehealth's role as a cornerstone of accessible, efficient health care delivery.

In light of the ASPE report and AHRQ-funded study findings, telehealth has been instrumental in maintaining access to essential health care services, especially during challenging times. The data supports permanent removal of geographic and site restrictions on telehealth services, as proposed by the CONNECT for Health Act and the Telehealth Modernization Act. By making these telehealth flexibilities permanent, Congress would be taking a significant step towards a more inclusive, accessible, and efficient health care system that is capable of meeting the needs of all patients, regardless of their geographical location or socioeconomic status.

Change Healthcare and Cybersecurity

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a

ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies and others. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians, hospitals and pharmacies, and delays in patient care.

In fact, on March 19th, Representatives Mariannette Miller-Meeks (R-IA) and Robin Kelly (D-IL), along with 96 bipartisan members of the House of Representatives, sent a letter to HHS Secretary Becerra alerting the administration of the ongoing challenges physicians and patients are continuing to experience as part of the Change Healthcare cyberattack. In addition to highlighting the inability of physician practices to file claims and receipt prompt payment, the letter urges CMS to clarify why they issued such stringent repayment terms as part of their March 9th announcement permitting advance payments for Part B physicians and other providers. The letter also highlights how individuals are being forced to pay out-of-pocket for pharmaceuticals and health care services due to the cyberattack, as well as pressed the Department for answers as to how it proposes to safeguard patients from the negative impact of their private health care information being inappropriately disclosed to malicious actors.

Overall, the attack demonstrates the vulnerability of our health care sector's infrastructure to cyber threats and the cascading effects these breaches can have on patient safety, privacy, and the overall delivery of care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

This incident is especially concerning for rural, remote, and underserved communities, where access to health care services is already limited. The reliance on digital platforms for telehealth and at-home care programs has been a lifeline for these communities, offering a measure of parity in access to essential health care services. However, the cybersecurity vulnerabilities exposed by the attack on Change Healthcare reveal a potential gap in our efforts to extend health care equity through digital means. As noted in the March 21st letter led by Vice Chairman Vern Buchanan and 19 Ways and Means members, a 2022 AMA study found that nearly 75 percent of patients expressed concern about protecting their personal health data.

The technical and financial burden of implementing cybersecurity should not be placed solely on physicians or the hospitals. Congress must provide important financial resources to assist physician practices with the challenge of protecting health care data. Ensuring the security of digital health care services is not merely about protecting data but about safeguarding the continuity of care for the most vulnerable populations in our society.

ELECTRONIC FUND TRANSFER (EFT) FEES AND REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE

The AMA recognizes the critical need to address financial and administrative inefficiencies that detract from our health care system's ability to serve rural and underserved communities effectively. A pressing issue in this context is the undue financial strain imposed on physicians and health care providers by unnecessary fees for Electronic Fund Transfers (EFTs).

The burden of 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. These fees, which can range from two percent to five percent of the claim payment, are levied by some health plans and their vendors without explicit agreement from practices, thereby exacerbating the administrative burdens on physicians. This issue is especially significant for health care providers in rural and underserved areas, where financial resources are already stretched thin, and administrative burdens can significantly impact the quality and accessibility of patient care.

By eliminating these predatory fees, the "No Fees for EFTs Act" would make a substantial contribution toward reducing administrative complexities, allowing physicians to allocate more resources towards patient care rather than navigating financial obstacles. This legislative action is particularly crucial in supporting the sustainability of telehealth and Hospital at Home programs, which have become vital in bridging the health care access gap in rural and underserved communities.

Furthermore, the administrative burden associated with managing EFT fees detracts from the time and attention health care providers can dedicate to patient care, including providing more services at home. In an era where every resource should be directed toward enhancing patient outcomes and accessibility, it is counterproductive to allow such financial inefficiencies to persist. As a result, we urge the Ways and Means Committee to exercise its jurisdictional authority over this issue and expeditiously pass this bill so physicians can devote more resources to things like investment in telehealth and other forms of at-homecare, which will bend the overarching cost curve of health care in the United States.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

Need for an Inflation Based Update to Physician Payment

The physician payment system is on an unsustainable path that threatens patients' access to physician services. This year, physicians faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed Medicare budget neutrality rules. Congress acted this month to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts completely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates fell 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

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

The current Medicare physician payment system—with its lack of an adequate annual physician payment update——is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the

government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, this pattern of last-minute stop gap measures must end. As the Committee looks to provide adequate payments to physicians, particularly those in rural and underserved areas, annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation.

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

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 Ways and Means Committee to pass H.R. 6371, the Provider Reimbursement Stability Act. In fact, the Energy and Commerce Committee already 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.

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.

Merit-based Incentive Payment System (MIPS)

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

Last year, the AMA responded to a Congressional RFI request from the House Committee on Ways and Means' on ways to improve health care in rural and underserved areas. In our comments, we highlight the difficulties experienced by health care providers, particularly small, rural, independent, and safety net practices, in adapting to the MIPS framework, especially in the context of the disruptions caused by the COVID-19 pandemic. We also proposed three key legislative changes aimed at mitigating the negative impacts of MIPS penalties, improving the timeliness and relevance of performance feedback and claims data provided by CMS, and making the program more clinically relevant while reducing the administrative burden on practices. We urge Congress to continue considering 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.

Private Equity and Health Care

The increasing presence of private equity in the health care sector raises important considerations for the sustainability and accessibility of health care services. With a notable shift in physician practice ownership from independent practices to those owned by hospitals, health systems, and private equity groups, there is an urgent need to examine the implications of these changes, especially in rural and underserved areas where health care options are already limited. Rural and underserved communities stand to be significantly impacted by the growing influence of private equity in health care. These areas, already grappling with a shortage of health care providers and limited access to medical services, may find themselves further marginalized by health care consolidation and the business-driven approaches of private equity-owned practices.

The AMA's observation of a decline in the percentage of physicians working in private practices highlights the potential for decreased health care autonomy and personalized patient care, aspects crucial for addressing the unique health challenges of these communities.The AMA supports legislation which creates a more equitable and transparent health care system that prioritizes patient care over profit. The aforementioned H.R. 2474 is one such proposal that seeks to ensure sustainable Medicare physician payment rates, a crucial factor in maintaining the viability of independent practices and, by extension, preserving access to high-quality health care in rural and underserved areas. Additionally, addressing systemic issues such as physician burnout, escalating practice expenses, and the administrative burdens of regulatory compliance are essential steps towards stabilizing the health care landscape. Legislative efforts such as MIPS improvements and prior authorization reforms can alleviate some of the pressures driving physicians towards private equity and other alternative ownership models.

CONCLUSION

The AMA is committed to working with Congress to find permanent solutions that ensure that Medicare beneficiaries have uninterrupted continued access to high quality, affordable health care which includes virtual care and care delivered in the home setting. We must build on the gains achieved during the pandemic so that all patients regardless of their zip code have access to the care they need.