The American College of Physicians (ACP) is pleased to provide our statement to the Senate Finance Subcommittee on Fiscal Responsibility and Economic Growth concerning The Hospital Insurance Trust Fund and the Future of Medicare Financing. We thank Senator Warren and Senator Cassidy for hosting this hearing to examine policies to ensure the fiscal solvency and long term sustainability of Medicare that provides insurance coverage for 60 million seniors and younger people with disabilities. Our statement will provide this subcommittee with our recommendations to enhance the value of care in Medicare through policies that would improve the Medicare Physician Fee Schedule (MPFS), reform the Medicare Access and CHIP Reauthorization Act (MACRA), enhance chronic care, strengthen Graduate Medical Education (GME), expand access to care through telehealth, and lower the cost of prescription drugs.

The American College of Physicians is the largest medical specialty organization and the second largest physician membership society in the United States. ACP members include 161,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Internal medicine specialists treat many of the patients at greatest risk from COVID-19, including the elderly and patients with pre-existing conditions like diabetes, heart disease and asthma.

In order to improve the fiscal solvency and sustainability of Medicare it is essential that the Senate Finance Committee conducts a review of the program to determine how well its coverage, payment, and delivery systems are working to ensure that Medicare can provide our seniors with a quality, affordable care that delivers the best possible outcomes for patients. The United States spends more on health care than other

appropriateness of those services, contributing to suboptimal outcomes. Beyond being wasteful, unnecessary services can harm the patient. It is clear that we can do better and we urge the Committee to adopt the following reforms to improve the quality and value of care provided in Medicare.

appreciates recent policies enacted by Congress and implemented by CMS to strengthen internal medicine by increasing payment under Medicare for office-based E/M services.

Prevent Medicare Sequestration Cuts

Although this hearing examines the long-term outlook for Medicare, Congress needs to address an issue in the short-term also since one of the Medicare cuts addressed in the **Protectg Medicare and American Farmers from Sequester Cuts Act** is a tree -month delay of the 2 percent Medicare sequester payment reducts (Jan. 1 to March 31) and a three-month, 1 percent reduct Medicare sequester payment reductns (April 1 t June 30). We urge the Senate to extend the full moratorium on the sequester cuts at least until the end of 2022.

All too often, physician payments are the targets for federal budget trimming and ways to pay for federal spending. Physician payments have also failed to keep up with the rate of inflatyon over the past 2 decades. Congress should prevent the cuts that would be imposed by sequestration to ensure that internal medicine physicians who have suffered significant financial, well-being, and health challenges imposed by the pandemic are able to keep their practices open to care for Medicare patients.

Improve the Medicare Access and Chip Reauthorization Act

In April of 2015, landmark legislation was signed int law that fundamentally restructred the Medicare physician payment system. The Medicare Access and CHIP Reauthorization Act (MACRA) instituted new policies under a new payment system called the Quality Payment Program (QPP) that rewards physicians based on the quality and value of services provided. Physicians participate in the QPP under one of two payment tracks: the Merit-Based Incentive Payment System (MIPS) or Alternative Payment Models (APMs).

Last year, we joined other physician organizations t submit a joint letter to the Senate Finance Committee to "respectfully request that the Senate Finance Committee convene one or more hearings on the implementation of physician payment policies within the MACRA, specifically focused on whether the current system achieves the Congressional intent to move towards value-based care. We also urge the Committee to consider the long-term viability of the current Medicare physician payment system." The committee last convened a hearing to examine the MACRA program in 2016 so we believe that nw would be an appropriate time to examine if it has achieved the object es of moving our health care system t one tat incentzes the quality and value of care that physicians provide to patients.

Merit-based Incentive Payment System

Most physicians participate in the Quality Payment Program (QPP) through the Merit Based Incent Payment System (MIPS) track, which builds on tradityonal fee -for-service payments by adjusting them based on a physician's performance. The MIPS program measures physicians' performance based on a scoring structre that req uires physicians to reprt performance data to CMS in 4 weighted categories: Quality Measurement, Improvement Activities, Promoting Interoperability and Cost. Physicians receive a score based on how well they perform in each of these categories, which then determines their Medicare payment.

The Merit-

Expand Primary Care Workforce through Graduate Medical Education

Improve Access to Care through Telehealth

new telehealth services to be added. ACP also appreciates the Agency adding coverage for outpatient cardiac rehabilitation to the Category 3 Medicare telehealth services list. The College strongly encourages CMS add coverage for audio-only evaluation and management telehealth services to the Category 3 list and retain these services until at least the end of CY23.

Pay Parity for Audio-Only and Telehealth Services

The College wholeheartedly supports many actions taken by CMS to provide additional flexibilities for patients and their doctors by providing payment for audio-only services. During the PHE, Medicare has covered some audio-only services for tele-mental health as well as evaluation and management services provided to patients and will reimburse for both telehealth services and audio-only services as if they were provided in person. Primary care services delivered via telephone have become essential to a sizable portion of Medicare beneficiaries who lack access to the technology necessary to conduct video visits. These services are instrumental for patients who do not have the requisite broadband/cellular phone networks, or do not feel comfortable using video visit technology. In addition, these changes have greatly aided physicians who have had to make up for lost revenue while still providing appropriate care to patients.

We are pleased that in the final 2022 Medicare Physician Fee Schedule Rule CMS is broadening the scope of services for which the geographic restrictions do not apply and for which the patient's home is a permissible geographic originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE. ACP supports any efforts to expand access to mental and behavioral health services, including allowing beneficiaries to access services from home, or if the technology is not available at home, from a rural health clinic or hospital.

We appreciate that the Telehealth Extension Act, H.R. 6202, would permanently lift geographic and site-based restrictions for additional telehealth services covered under Medicare regardless of a beneficiary's zip code, and in the comfort and convenience of their own home or at designated health facilities offering telehealth. We urge adoption of this provision that will increase access to telehealth services beyond mental and behavioral health services in any legislation that Congress chooses to advance on telehealth.

Telehealth Cost Sharing Waivers

ACP appreciated the flexibility previously provided by CMS to allow clinicians to reduce or waive cost-sharing for telehealth and audio-only telephone visits for the duration of the PHE. This critical action has led to increased uptake of telehealth visits by patients. At the same time, we call on CMS, or preferably Congress, to make up the difference between these waived copays and the Medicare allowed amount of the service. Many practices are struggling or closing. It is critical that CMS and other payers not add to the financial uncertainties already surrounding physicians. Given the enormity of the COVID-19 pandemic, cost should not be a prohibitive factor for patients in attaining telehealth services, including those related to mental and behavioral health treatment.

The College believes that the patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the PHE is lifted. At the conclusion of the COVID-19 PHE, ACP recommends that Congress urge, or if necessary, require CMS to continue to provide flexibility in the Medicare and Medicaid programs for physician practices to reduce or waive cost-sharing requirements for telehealth services, while also making up the difference between these waived copays and the Medicare allowed amount of the service. This action in concert with others has the potential to be transformative for practices while allowing them to innovate and continue to meet patients where they reside.

projections indicated that $456 billion in savings over 10 years would be realized by allowing Medicare to directly negotiate prescription drug prices with manufacturers.

We remain concerned that the House-passed BBBA does not include this more robust provision of price negotiation in H.R. 3. We believe that giving HHS the authority to negotiate drug prices with manufacturers is one of the most effective ways to lower the cost of prescription drugs and we urge lawmakers to include that provision of H.R. 3 or similar legislation in the final bill.

The House-passed BBBA allows HHS to negotiate the price of 10 of the most expensive drugs by 2025 and going up to 20 drugs by 2028 on drugs that are beyond their period of exclusivity. The bill applies an excise tax on drug manufacturers for raising prices faster than the rate of inflation, reduces out-of-pocket expenses for customers and ensures patients pay no more than $35 a month for insulin products. While ACP reaffirms its support for a full repeal of the noninterference clause, ACP is also supportive of an interim approach, such as allowing the Secretary of HHS to negotiate for a limited set of high-cost or sole-source drugs.

Conclusion

We appreciate the opportunity to provide our views to the Finance Committee on this important topic that should be addressed as the baby-boomer generation ages and Medicare expenditures are expected to continue to grow in the coming years. We urge the Committee to address the issues in our statement to ensure that Medicare can provide the most efficient and effective care for our nation's seniors and individuals with disabilities. Should you have any questions regarding our statement, please do not hesitate to contact Brian Buckley at