The American College of Physicians (ACP) is pleased to provide comments to the House Ways and Means Committee on its Request for Information (RFI)

25 Massachusetts Avenue, NW, Suite 700, Washington, DC 20001-7401 | 202-261-4500, 800-338-3746 | www.acponline.org

our investment in primary care as evidence shows that it is critical for achieving health care's quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience). Now, with the closure of many physician practices and physicians nearing retirement not returning to the workforce after the COVID-19 pandemic, it is even more imperative to assist those clinicians serving on the frontlines and increase the number of future physicians in the pipeline.

Remove Student Debt as a Barrier to Patient Care

ACP is greatly concerned by the already high and ever-increasing cost of obtaining a medical education and the effect those expenses have on the number of medical students and residents opting to enter

- Support H.R. 2630/S. 652, the *Safe Step Act of 2023*, a bipartisan bill that would ensure patient access to appropriate treatments based on clinical decision-making and medical necessity rather than arbitrary step therapy protocols. The bill would require group health plans to provide a transparent exception process for any medication step therapy protocol.
- Support legislation that facilitates electronic health record (EHR) standardization and the adoption of new standards in medical practices that would reduce burdensome administrative tasks.

Protecting Viable Primary Care Practices During Consolidation

The Committee seeks comments on ways to ensure independent practices remain a viable option in a highly consolidated health marketplace. Research is needed to better understand the effect of private equity investment in health care. ACP recommends longitudinal research on the effect of private equity investment on physicians' clinical decision making, health care prices, access and patient care, including the characteristics of models that may have adverse or positive effects on the quality and cost of care and the patient–physician relationship. We believe passage of H.R. 5378, *Lower Costs, More Transparency Act*, is a good start at examining the effects of consolidation on independent practices. While the bill does not include private equity, it does require the Department of Health and Human Services to collect data on how its regulations affect consolidation.

ACP supports transparency regarding corporate and private equity investment in the health care industry. Policymakers, stakeholders and regulators should provide oversight of private equity activity to prevent practices like unwarranted self-referral, overreliance on nonphysician health care professionals, or consolidation that results in uncompetitive markets. While greater transparency and data collection of vertical integration activity is an important first step, ACP recommends that lawmakers and regulators scrutinize in advance and regularly evaluate after approval all mergers, acquisitions, and buyouts involving health care entities, including insurers, pharmacy chains, large physician groups, and hospitals.

The Committee is requesting comments on policies to lower patient costs for patients by equalizing payments for identical care provided at different settings of care. Moreover, how should Congress approach equalized payment policies that lower costs while preserving access to care and discouraging health care consolidation.

ACP believes that site neutrality is good policy for Medicare, Medicare beneficiaries, and the health care system as a whole. Historically, Medicare has typically paid a higher rate for the same service when performed at a hospital outpatient department (HOPD) rather than a physician's office. Site of

service payment differentials create an incentive for hospitals to acquire physicians' practices and rebrand them as HOPDs, causing the magnitude of this problem to grow over time.

While site of-service payment differentials are not the only factor driving hospitals to acquire physician practices, they likely do play a major role. Embracing a policy of site-neutral payments could thus save Medicare considerable dollars. We do not believe that care delivered in a HOPD should be paid a higher rate when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's High-Value Care initiative, ACP supports delivery of care in the most efficient setting, while maintaining quality of care. Additionally, any changes must not negatively affect Safety-Net organizations, deny or restrict coverage of care provided by qualified and approved clinicians, or jeopardize access to primary and preventive care for millions of Americans who rely on our Nation's already stretched health care safety net. Coverage decisions should be based solely on medical evidence, best practices, and qualifications. Provider-based billing should not be used as a mechanism for hospitals to recoup/stabilize funding or as a means of ensuring access to care. Ensuring adequate hospital funding and patients' access to care can better be addressed and supported through other means, such as increased/improved health insurance coverage, strengthened workforce policies, and delivery system reforms.

The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas.

First, Congress should provide resources and support to CMS in the development of APMs. It should extend the five percent bonus for physician participation in advanced APMs. ACP urges Congress to pass H.R. 5013, the *Value in Health Care Act of 2023*, to extend MACRA's five percent advanced APM incentives that are scheduled to expire at the end of the year. That bill also gives CMS authority to adjust APM qualifying thresholds so that the current one-size-fits-all approach does not serve as a disincentive to including rural, underserved, primary care or specialty practices in APMs. The bill removes revenue-based distinctions that disadvantage rural and safety net providers, which is critical to improving access to care and improving health equity. This bipartisan legislation makes several important reforms to ensure that APMs continue to produce high quality care for the Medicare program and its beneficiaries.

Second, few APMs are available to physicians. The Physician-Focused Payment Model Technical Advisory Committee (PTAC) mandated by the Medicare Access and CHIP Reauthorization Act of 2015, recommends new pccess esources and suppoovinq0 G[-)]TJETQq0.00000912 0 612 792 reW*nBT/F1 12 Tf1 0 03(p)

Third, despite the lack of APMs, we support the "Making Care Primary Model" being implemented through the Centers for Medicare and Medicaid Innovation (CMMI) in eight states. This model for primary care is structured to facilitate and promote care coordination between primary care physicians and other specialists. The model aligns with recommendations in ACP's paper, "Beyond the Referral: Principles of Effective, Ongoing Primary and Specialty Care Collaboration."

The Making Care Primary Model is designed to provide primary care clinicians with enhanced payments, tools, and support to improve the health outcomes of their patients. It incorporates key elements that ACP proposed in the Medical Home Neighborhood Model. That model will provide a great number of opportunities for subspecialisLaci8 655.95 28.5 0.75 9.95 28.5 0-4( )-2(th)6(at A)-5(C)-8en f4(p)4(c