



**Association of
American Medical Colleges**
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

October 10, 2023

The Honorable Jodey Arrington
Chair
Budget Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Burgess, MD
Chair
Budget Committee Health Care Task Force
U.S. House of Representatives
Washington, DC 20515

Re: Budget Committee Health Care Task Force Request for Information

Dear Budget Committee Chair Arrington and Task Force Committee Chair Burgess:

On behalf of the Association of American Medical Colleges (AAMC), I write to respond to your [August 25 request for information](#) on ways to improve patient outcomes and reduce federal spending. The AAMC is dedicated to improving the health of people everywhere, and is invested in ensuring that federal programs that support this mission remain strong, well-funded, and fully operational.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 12 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The AAMC and our member teaching health systems and hospitals and their faculty physicians are committed to delivering high-quality, comprehensive patient care in all communities across the United States. Our members are health, social and economic anchors of their communities with their commitment to their missions of patient care, education, research, and community collaboration. These missions, which are critical now more than ever, are in jeopardy as AAMC-member institutions are forced to make difficult financial decisions that stand to dramatically impact the patients and communities they serve. For instance, decisions about maintaining hospital operations that include specialized services that cannot be found elsewhere, such as burn units, inpatient psychiatry care, and trauma centers, or whether to cut or even eliminate key workforce training programs as the nation

continues to grapple with a worsening physician shortage. Our member institutions have been pushed to the brink, and patients across the country will likely lose access to the care they need if Congress takes actions that further deplete their financial stability.

While operating a health system, particularly an academic one, has always been challenging, financial pressures have increased significantly in recent years. The AAMC has shared concerns from across its membership about shrinking and negative margins, a reality that is reflective of a broader trend in the U.S., with about half of U.S. hospitals ending 2022 with a negative margin. Though some challenges can be attributed to recovery from the COVID-19 public health emergency (PHE) and general economic conditions, certain systemic issues persist, including staffing challenges, a shrinking financial base, and ever-increasing mission-related costs.

The AAMC remains committed to working with Congress to find ways to provide more value and reduce unnecessary spending in health care, but we must caution the Task Force against any proposals that would further cut provider payments and ultimately harm patient access to care. Historically, some measures have been propagated which, sometimes inadvertently, would reduce hospital and physician payments, consolidate critical workforce programs, and cut beneficiary access to care. The AAMC urges you to avoid these types of measures and instead, consider our below response to this RFI.

Regulatory, statutory, or implementation barriers that could be addressed to reduce health care spending

Protect Medicare and Medicaid and increase payment rates

The AAMC urges the Task Force to reject proposals to make cuts to Medicare or Medicaid. Millions of patients across the US rely on these programs to connect them with the care that they need, and teaching hospitals and health systems disproportionately care for these patients. Despite comprising just 5% of hospitals in the US, AAMC member teaching health systems provide 23% of all Medicare inpatient days, 26% of all Medicaid inpatient days, and 32% of hospital charity care.¹ Our members are committed to ensuring that these patients have access to high-quality care regardless of their insurance coverage or ability to pay.

Not only does the AAMC urge you to ensure that Medicare and Medicaid are unharmed in any budget proposals, but we urge the Task Force to increase Medicare hospital and physician payment rates. The AAMC remains strongly concerned that Medicare payment rates do not adequately reflect the significantly higher growth in labor and supply costs that hospitals have experienced as a result of record inflation and the COVID-19 PHE. In aggregate, AAMC member teaching health systems and hospitals are experiencing -18.8% Medicare margins.² In its March 2023 report to Congress, MedPAC notes that “hospitals’ Medicare margins in 2023 will be lower than in 2021, driven in part by growth in hospitals’ input costs, which exceeded the forecasts the Centers for Medicare & Medicaid Services (CMS) used to

¹ AAMC analysis of FY2021 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute’s Office of Cancer Centers, 2022. AAMC membership data, December 2022.

² AAMC analysis of FY2020 the Hospital Cost Reporting Information System (HCRIS) released on July 30, 2022. AAMC membership data, September 2022.

set Medicare payment rate updates.”³ Further, recent reporting indicates that labor costs are 19 percent higher year-to-date in March 2023 as compared to March 2020.⁴ While some pressures are beginning to ease as care utilization stabilizes, our members are still being asked to do more with insufficient reimbursement.

CMS continues to provide inadequate market basket updates for provider payments due to its reliance on forecasts rather than actual historical labor and supply cost increases, and this fails to acknowledge and incorporate the challenging circumstances brought on by the pandemic. Therefore, using the current methodology to calculate the payment update inaccurately estimates the financial strain hospitals have experienced and will continue to experience in FY 2024 and is insufficient to address these cost increases. Action is needed to ensure adequate updates to the market basket, particularly in light of the exceptional circumstances our members are facing – including increased labor costs, which are expected to remain, and the continued financial struggles of hospitals as they try to maintain access to services. The AAMC and other organizations have called on CMS to remedy errors in their market basket calculations, and we believe that Congress should require this action.⁵ It is important to note that market basket miscalculations, and resulting underpayments, are inappropriately incorporated into the Medicare baseline, meaning that underpayments will only continue and multiply unless CMS corrects this forecast. This results in millions of dollars of loss to hospitals every year.

Reform Medicare physician payment and pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474)

Physician payments also have failed to keep pace with rising inflation and practice costs. An analysis by the American Medical Association (AMA) found that from 2001 to 2023, Medicare physician payments have increased only nine percent, while the cost of running a medical practice has increased 47 percent.⁶ The AAMC is concerned that additional reductions in revenue for physicians combined with workforce shortages could result in even greater access problems for patients, including those in rural and other underserved communities. Continued cuts to physician payment will further strain the physician workforce and are likely to trigger further early retirement or reduction in physician services during a time when physicians are needed the most in their communities. According to the AAMC’s projections, by 2034 the country could experience a shortfall of up to 124,000 physicians.⁷ These shortages would likely be exacerbated if physicians face these cuts in payment.

MedPAC agrees that Medicare physician payment should be increased, and recommended this year that Congress increase the 2024 Medicare physician payment rate above current law with an inflation-based payment update tied to the Medicare Economic Index (MEI). According to MedPAC, of those Medicare beneficiaries looking for a new primary care physician, half had difficulties finding one, and of those beneficiaries looking for a new specialist, one-third had difficulties finding one.⁸ The Medicare Trustees also expressed concern with the failure of Medicare to keep pace with the cost of running a practice in

³ Medicare Payment Advisory Commission. March 2023 Report to Congress.

https://www.medpac.gov/wpcontent/uploads/2023/03/Ch3_Mar23_MedPAC_Report_To_Congress_SEC.pdf

⁴ Kaufman Hall, "National Hospital Flash Report," April 2023, https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf.

⁵ AAMC Letter to CMS on FY 2023 IPPS, June 2023: <https://www.aamc.org/media/68321/download?attachment>

⁶ AMA Snapshot, [Medicare updates compared to inflation \(2001 – 2023\)](#) (2023)

⁷ AAMC, [The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 \(Jun. 2021\)](#)

⁸ MedPAC, [Report to Congress, Medicare Payment Policy, Chapter 4](#) (Mar. 2023)

their 2023 report. The Trustees warned that they expect access to Medicare-participating physicians to become a significant issue in the long term.⁹

Given these unprecedented challenges and the critical importance of patient access to health care services, we encourage the Task Force to work with committees of jurisdiction to include in the Congressional budget and pass legislation, including the Strengthening Medicare for Patients and Providers Act (H.R. 2474), which would provide an annual inflation-based payment update based on the MEI. This would help ensure that physicians and other health care providers can continue to provide high-quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Address budget neutrality in the Physician Fee Schedule

Another challenge that must be addressed in the Physician Fee Schedule (PFS) is that of budget-neutrality, which has constrained Medicare provider payments for many years and led to arbitrary reductions in reimbursement. A budget-neutral payment system stifles physician payment and has proven to be incredibly problematic. The updates to the conversion factor have not kept up with inflation, while the cost of running a medical practice has increased significantly. At a minimum, we recommend that budget neutrality policies be revised to ensure that utilization estimates are accurate, that certain categories of services (e.g., newly covered Medicare services, health professions added, new technology, etc.) are exempt from future budget neutrality adjustments, and that the \$20 million threshold that triggers budget neutrality is raised to at least \$100 million. We urge you to incorporate these changes in the congressional budget and work collaboratively with your colleagues on the Energy and Commerce Committee and in the Senate to address this issue that, if left unaddressed, will continue to plague the physician payment system.

Invest in the physician workforce and maintain access to care for all communities

The health care workforce in the US is in a dire state due to myriad factors including burnout, COVID-19, unprecedented violence against providers, and aging. The US is projected to face a physician shortage of up to 124,000 physicians by 2034 in both primary care and specialty care.¹⁰ As the AAMC has discussed with you, these shortages in physician supply will have a real impact on patients, particularly those living in rural, frontier, island, or non-contiguous settings, as well as other already underserved communities. The AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need to add an additional 102,400 to 180,400 physicians immediately just to meet current demand.¹¹ These estimates, which are separate from the 2034 shortage projection ranges, illustrate the magnitude of current barriers to care and provide an additional reference point when gauging the inadequacy of physician workforce supply.

Addressing the nation's physician workforce shortages in both primary care and other needed specialties requires a multipronged, innovative, public-private approach beyond just increasing the overall number

⁹ [2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds](#) (Mar. 2023)

¹⁰ [The Complexities of Physician Supply and Demand](#): Projections From 2019 to 2034, Prepared for the AAMC by IHS Markit Ltd., June 2021.

¹¹ Ibid.

of physicians, including implementing team-based care models and furthering the use of technology. We support innovative solutions to address health workforce shortages. Since the academic year 2002-2003, total medical school enrollment has grown by more than 38 percent, as medical schools have expanded class sizes and more than 32 new medical schools have opened. Indeed, our institutions have risen to the challenge, taking serious steps to enroll, educate, and produce more physicians. This expansion has been thoughtful, deliberate, and with significant cost – our institutions should be acknowledged and applauded. While this increase is encouraging, additional action is still needed to address the physician shortage.

Physician and hospital payments certainly contribute to workforce shortages and facility closures. Providers are being expected to do more with less, with many smaller practices realizing that keeping up with administrative burden and rising costs is simply not sustainable. Teaching health systems and hospitals, in particular, incur costs that other facilities do not due to their mission-focused work, and they require tremendous resources to operate. As mentioned earlier, reimbursement has not kept pace with these rising costs, potentially forcing teaching health systems and hospitals to make difficult decisions about their investments in workforce programs.

The AAMC appreciates and applauds that Congress has taken bipartisan steps to expand Medicare support for graduate medical education (GME) to help address current and projected physician shortages. In fact, the 1,200 new positions that Congress provided in the Consolidated Appropriations Act, 2021 and the Consolidated Appropriations Act, 2023, represented the first new investment in Medicare-supported GME since 1997. The AAMC urges the Task Force and Congress to build upon these historic efforts and to enhance investment in Medicare-supported GME, which helps offset a portion of the costs associated with operating residency training programs. As the nation's population ages and requires more medical care, it is imperative that the physician workforce is equipped to meet the needs of patients and communities. For this reason, the AAMC urges the Task Force to work with committees of jurisdiction to include in the Congressional budget and pass the bipartisan Resident Physician Shortage Reduction Act of 2023 (H.R. 2389), which would gradually increase the number of Medicare-supported GME positions by 2,000 per year over seven years.

Additionally, we urge the Task Force to reject misguided workforce proposals that would cut or consolidate federal GME programs in the name of "health care savings." Slashing Medicare support for teaching health systems and hospitals' unique patient care missions or consolidating Medicare, Medicaid, and Children's Hospital GME into a one-size fits all grant program would exacerbate the projected physician shortage by forcing teaching hospitals to absorb billions in untenable cuts. We urge Congress to build on those recent bipartisan successes and support federal investment in GME to ensure an adequate physician workforce to care for Medicare beneficiaries and support the critical patient care missions of America's teaching hospitals. Dramatically reducing this essential federal investment in the missions of teaching hospitals would mean fewer physicians and decreased access to care for patients, including access to potentially critical services.

Reduce administrative burden on hospitals and physicians

AAMC-member teaching health systems and hospitals and their faculty physicians are committed to providing the best possible care for their patients, and must navigate an extraordinarily complex environment of rules, regulations, and red tape. Administrative burden contributes to worsening burnout

among physicians and other clinicians, and leads providers to spend more time working through paperwork than treating patients. It also increases hospital costs and drives up the overall cost of health care as hospitals dedicate significant resources to meeting increasing administrative burden.

Several recent congressional proposals aimed at increasing transparency stand to further burden providers and increase the costs of providing health care. While oft well-intentioned, the AAMC urges the committee to weigh the perceived benefits of transparency with the costs to providers and the health care system. For example, the Lower Costs, More Transparency Act (H.R. 5738) would impose a national provider identifier (NPI) on all HOPDs. The AAMC believes that this policy would impose additional administrative and financial burdens on our members. Teaching health systems and hospitals are complex entities that must already dedicate substantial financial resources to billing. This provision would require hospitals to invest additional resources to update their billing and IT systems and reorganize workflows to comply with these new regulations. AAMC member teaching health systems and hospitals are already facing immense financial pressures, therefore complying with additional and unnecessary reporting requirements only stands to further squeeze hospitals, jeopardize patient access to care, and increase health care costs. For over 20 years, Members of Congress (of both parties), as well as various Administrations have tried to reduce administrative burden. Most agree on the need, and more work needs to be done to truly rein in the cost and redundancy of regulation. The AAMC urges the Task Force to avoid burdensome measures in future legislation.

Address prior authorization abuse

Increased utilization of prior authorization has emerged as a common way for insurers to delay or ultimately deny care to patients. Though prior authorization practices are an administrative albatross to physicians participating in insurance networks across the country, a spotlight has recently been shined on the Medicare Advantage program. Medicare Advantage beneficiaries should receive the same care and benefits as those in traditional Medicare. However, many Medicare Advantage patients must wait for pre-approval of common treatments. This extra administrative step places a significant burden on physicians and can also result in adverse effects on patient care. A study conducted by the Office of Inspector General (OIG) in the Department of Health and Human Services (HHS) demonstrated that 75 percent of initially rejected services and procedures were overturned by Medicare Advantage when appealed by providers.¹² Having to consistently appeal these decisions only to have the vast majority of them overturned is inefficient and places unnecessary stress on both patients and providers. It also places patients at risk. An AMA survey conducted in December 2021 found that 93 percent of physicians saw delays in care due to prior authorization and 82 percent said the delays caused by prior authorization caused patients to forgo treatment altogether.^{13, 14} Patients cannot afford these artificial delays or barriers to care.

The AAMC is pleased that the Ways and Means committee passed the bipartisan Improving Seniors' Timely Access to Care Act (H.R. 3173), which would streamline patient care and allow faculty physicians and other providers at teaching hospitals to spend more time treating patients and training the

¹² U.S. Department of Health and Human Services, Office of Inspector General, [Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials](#); Report (OEI-09-16-00410) (Sept. 2018).

¹³ American Medical Association, [2021 AMA Prior Authorization \(PA\) Physician Survey](#); (Dec. 2021).

next generation of physicians. The AAMC urges the Task Force to seek additional opportunities to ensure that insurers are not burdening providers with administrative hurdles that prevent patients from accessing the care that they need.

Make key COVID-19 telehealth flexibilities permanent

Throughout the COVID-19 public health emergency (PHE), Congress authorized and CMS implemented numerous waivers and flexibilities that vastly improved patient access to care. Congress extended some of these key waivers and flexibilities until Dec. 31, 2024 through the Consolidated Appropriations Act, 2023, but without further Congressional action they will expire. To that end, the AAMC urges you to consider making the following COVID-19-related waivers and flexibilities permanent:

- *Allow payment for telehealth services in all geographic locations, including the patient's home*
- *Allow payment for audio-only telehealth services*
- *Allow physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), and audiologists to provide telehealth services*
- *Allow payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for telehealth services*
- *Remove in-person visit requirements for mental health services*

Ensure the continued move to value-based care by passing the Value in Health Care Act (H.R. 5013)

The AAMC strongly supports the Value in Health Care Act (H.R. 5013). This bipartisan legislation would make needed reforms to alternative payment models (APMs) and help increase the adoption of value-based care models, which seek to link payment to quality of care as opposed to volume of services. APMs stand to create savings in the Medicare program, furthering its solvency, while also ensuring that patients have access to high-quality care. H.R. 5013 would extend the Medicare and CHIP Reauthorization Act's (MACRA, P.L. 114-10) advanced APM incentives that are scheduled to expire on Dec. 31, 2023, and also endow CMS with the authority to adjust qualifying thresholds to ensure that rural, underserved, primary care and specialty practices are not disincentivized to participate. The bill would also remove revenue-based distinctions that disadvantage rural and safety-net providers. Among other improvements, the H.R. 5013 would also establish a voluntary track for accountable care organizations (ACOs) in the Medicare Shared Savings Program to take on higher levels of risk, as well as provide technical assistance for clinicians new to APMs. The AAMC urges the Task Force to incorporate these policies into the congressional budget and support passage of this legislation, and in particular, take action to ensure that the advanced APM incentives do not expire on Dec. 31, 2023.

Align quality measures across programs

The AAMC urges the Task Force to consider efforts to align quality measures across programs. One way to achieve this alignment is to utilize more registry-based measures where they exist. This also reduces the administrative burden for the participants. Many of the alternative measure sets available in current programs like CMMI's BPCI Advanced successfully utilize registry data that providers are already collecting to create clinically meaningful quality metrics. Choosing well-established registries also provides opportunities for physician engagement by utilizing familiar measure sets they are accustomed to reviewing. The inclusion of clinical data allows for actual clinical outcomes to

appropriately impact reimbursement, as with the assessments for quality improvement and patient safety.

Registries reduce reporting burden for participants because they are already reporting this registry data. Registries already have physicians engaged in their reporting structures, so it is not additional data they need to collect. In addition, registries are focused on clinically actionable metrics which makes them more useful in a clinical setting.

Promote the Use of Interprofessional Consults and Eliminate Barriers

The AAMC and its member health systems have found the use of provider-to-provider telehealth modalities and peer-mentored care as important ways to improve access to care, particularly for specialties like behavioral health where there are significant access and workforce challenges. However, interprofessional consults have been underutilized due to obstacles related to payment policies, some of which are summarized below.

The AAMC has partnered with over 50 adult and pediatric health systems through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional consults (“eConsults”) and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high-value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist’s guidance as well as decreased out-of-pocket costs, including a specialist visit, travel, and time away from work. eConsults can be particularly beneficial for rural patients who may face challenges around access to care and long travel times to see a specialist. Payers also benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs.

However, there are several barriers to the use of Interprofessional Consults, including challenges with interoperability across systems, the code descriptors, and requirements related to coinsurance.

CMS requires that providers collect coinsurance from their patients when billing for interprofessional consults. The coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider and one for the consulting provider. While we believe that it is appropriate to reimburse both providers for their work in conducting the interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service predictably causes confusion. Additionally, interprofessional consults are often used for patients with new problems who are not established within the consulting specialty’s practice and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred.

We continue to believe that the “two coinsurances” issue will stifle the use of these value-promoting, physician-to-physician services that saves costs to the Medicare program. Therefore, we ask the Task Force to work with committees of jurisdiction to consider where there may be pathways to waive the patient coinsurance for these important services.

More broadly, we urge the Task Force to explore and work with the committees of jurisdiction to advance policies that increase interoperability thereby reducing costs and improving access to care.

Efforts to promote and incorporate innovation into programs like Medicare to reduce health care spending and improve patient outcomes.

Increase access to integrated behavioral health care services

Integrated behavioral health (IBH) involves a multidisciplinary team of medical and behavioral health providers working together to address the medical, behavioral, and social factors that affect a patient’s health and well-being. IBH models address fragmented systems of care by improving care coordination and ensuring that medical and mental health conditions are effectively co-managed. In addition, IBH models help to reduce the stigma associated with mental health care by allowing patients to conveniently receive behavioral health services within primary or specialty care settings. IBH models help to expand access to mental health services in underserved communities by improving the capacity of the existing behavioral health workforce to meet patient demand. These models are particularly beneficial for rural communities, who have historically struggled to access mental health services due to recurring provider shortages, stigma, and other barriers to care.

Not only do IBH models improve patients’ experience and access to care, but they are also associated with long-term cost savings. IBH models can address emergency department (ED) overcrowding by connecting patients with necessary mental health care before their case escalates to a psychiatric emergency. Numerous trials and studies have demonstrated that evidence-based integrated behavioral health models are associated with long-term health care savings.¹⁵ To incentivize the adoption of these innovative, cost-effective models, Congress should explore policies to promote the long-term financial sustainability of IBH training and patient care models. The AAMC encourages you to review our recommendations to promote the integration of physical and mental health in our brochure “[Focusing on Mental and Behavioral Health Care](#).” The AAMC urges the Task Force to support the inclusion of these policies in the congressional budget and work to advance related legislative efforts.

Examples of evidence-based, cost-effective preventive health measures or interventions that can reduce long-term health costs

Ensuring patients’ access to preventive health care and early intervention is essential to improving the quality and longevity of life for millions, as well as reducing long-term health care spending. By

¹⁵ University of Washington AIMS Center: <https://aims.uw.edu/collaborative-care/building-business-case-cost-effectiveness-studies-collaborative-care>

detecting and treating chronic diseases and acute conditions early, preventive services have the potential to extend and improve patients' lives. These services benefit the public by lowering costs for patients, providers, and payers, including the federal government.

Provide comprehensive coverage for all

Access to coverage is a key predictor of an individual's likelihood of seeking and receiving vital preventive services. To help patients access these services, the AAMC supports policies to provide comprehensive, affordable health coverage for all. This is particularly important during the perinatal period, during which new mothers may develop serious health complications like mental health conditions, hypertension, and cardiovascular disease. To support the early detection and treatment of these conditions, the AAMC supports policies to extend Medicaid coverage up to 12 months postpartum. These policies can reduce health care spending over the long term by supporting pregnant and postpartum patients' access to medically necessary preventive services, thereby reducing the risk of severe injury and death.

We also urge the Task Force to refrain from advancing policies that would fundamentally undermine the health care safety-net. Specifically, the implementation of Medicaid block grants or per-capita caps. These policies would result in reductions in coverage, access, and care for the millions of vulnerable patients who rely on this program to receive the health care they need. More than 26% of all Medicaid hospitalizations occur at AAMC-member teaching health systems and hospitals, even though these institutions represent only 5% of all hospitals. These policies would reduce access to care and be devastating for patients.

Enable social determinants of health risk assessments to be payable with no beneficiary cost-sharing

In the 2024 PFS proposed rule, CMS proposed to allow payment for a social determinants of health (SDOH) risk assessment that includes the administration of a standardized evidence-based tool that includes food insecurity, housing insecurity, transportation needs, and utility difficulties. The SDOH risk assessment is considered reasonable and necessary when used to inform the patient's diagnosis and treatment plan established during the visit.

The AAMC supports recognition of the work involved in administering an SDOH risk assessment as this will enable practitioners to gain a more thorough understanding of the patient's full social history and determine whether social needs are impacting medically necessary care. This assessment is beneficial as it could inform the care the patient receives and encourage partnerships with community-based organizations. Whole person care is critical for treating illness and injury and community health workers are an important part of teams by providing social care assistance and peer support to improve health. These services can help to reduce barriers, expand access, and promote health care equity for underserved patients, particularly those with unmet health-related social needs. Because this SDOH risk assessment is preventive, we urge Congress and CMS to enable these risk assessments to be payable with no beneficiary cost-sharing.

Prevent mental and behavioral health conditions by expanding coverage and reimbursement for social needs screenings

Prevention of mental and behavioral health conditions is critical. About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. Mental and behavioral

health disorders affect people of all ages and racial/ethnic backgrounds with some populations being disproportionately impacted. There are many factors impacting mental and behavioral health that are not part of the health care system. For example, social factors such as where someone lives, the way they live, and their profession are important for health outcomes. Individuals who have trouble accessing mental and behavioral health services often struggle with social needs that are a source or significantly contribute to their mental and behavioral health status. AAMC-member health systems are integrating screenings to better understand patients' social needs (e.g., social determinants of health). Expanding coverage and reimbursement for social needs screening is necessary to adequately address the current crisis and attempt to mitigate future challenges. The AAMC urges the Task Force to support the inclusion of these policies in the congressional budget and work to advance related legislative efforts.

Thank you for the opportunity to provide input on this RFI. The AAMC looks forward to continuing to work with you to improve the health of all and ensure that federal programs remain strong for the millions of patients who rely on them. If you have any further questions, please contact my colleagues Leonard Marquez, Senior Director of Government Relations & Legislative Advocacy (lmarquez@aamc.org), or Ally Perleoni, Director of Government Relations (aperleoni@aamc.org).

Sincerely,

A handwritten signature in black ink that reads "Danielle P. Turnipseed". The signature is written in a cursive, flowing style.

Danielle Turnipseed, JD, MHSA, MPP
Chief Public Policy Officer
Association of American Medical Colleges

CC: David J. Skorton, MD
President and CEO
Association of American Medical Colleges