AMERICAN ACADEMY OF FAMILY PHYSICIANS

December 5, 2023

The Honorable Marianette Miller-Meeks
U.S. House of Representatives
1034 Longworth House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier
U.S. House of Representatives
1110 Longworth House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Robin Kelly
U.S. House of Representatives
2329 Rayburn House Office Building
Washington, D.C. 20515

Dear Representatives Miller-Meeks, Schrier, Bucshon, and Kelly:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to thank you all for your bipartisanship leadership on issues impacting family physicians and their patients and to offer our support for the *Physician Fee Schedule Update and Improvements Act* (H.R. 6545).

The Medicare Access and CHIP Reauthorization Act (MACRA) sought to create incentives in Medicare to provide seniors with better quality care rather than just greater volume of care. It permanently repealed the sustainable growth rate (SGR) and set up the two-track Quality Payment Program (QPP) that emphasizes value-based payment. However, while the elimination of the SGR was lauded by the physician community at the time, MACRA has left the majority of Part B clinicians in a similar state of financial insecurity as Medicare payment rates have failed to keep pace with practice costs amid a dearth of value-based payment model options. We have consistently urged Congress to work with the physician community to address MACRA's shortcomings and protect beneficiaries' timely access to care, including by:

- **Providing physicians with financial relief from the full 3.4 percent payment cut they are facing in 2024**, without in any way delaying the implementation of the add-on code known as G2211;
- **Implementing long-term reforms to the Medicare Physician Fee Schedule, including an annual inflationary update and addressing budget neutrality requirements**, which hamstring CMS' ability to appropriately pay for all the services a beneficiary needs;
- **Extending the physician work Geographic Cost Practice Index (GPCI) floor of 1.0** to ensure that rural practices are not taking additional financial hits that threaten their ability to stay afloat; and
- **Extending the advanced alternative payment model (AAPM) incentive payment.**

Last month, CMS finalized the Calendar Year 2024 MPFS, in which they included policies that will better support Medicare beneficiaries' access to longitudinal, comprehensive primary care, including implementation of the G2211 add-on code for outpatient/office-based evaluation and management



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visits. The AAFP strongly believes that G2211 will more appropriately value the complex, continuous services family physicians provide as part of an ongoing relationship with a patient and **we continue to urge Congress to be supportive of this proposal by doing nothing to delay its implementation.**

Despite these investments, however, **the AAFP remains deeply concerned that a finalized reduction of 3.4 percent to the Medicare conversion factor will result in untenable payment cuts for all physicians**. Physician practices across the country are facing a barrage of converging policy developments in 2024 that threaten to worsen a growing primary care crisis. Both MedPAC and the Board of Trustees have recently raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[1]

Therefore, we appreciate that your legislation addresses each of the four policy issues outlined above that the Academy has been continuously advocating on. Specifically, your legislation would increase the statutorily provided relief from Medicare physician payment cuts to 3 percent for 2024, takes important first steps to address some of the long-standing issues with budget neutrality requirements, and reauthorizes both the work GPCI floor and the AAPM incentive payment.

Physician payment is one of the only systems under Medicare that does not currently receive an annual inflationary update. There is a significant discrepancy between what it costs to run a physician practice and the actual payment we receive, placing many small, independent practices in a state of financial ruin that leaves them with virtually no options other than to be acquired by a health system or payer, or close their doors entirely. We support the necessary short-term relief your legislation provides to physicians for the upcoming year, but **the Academy continues to advocate alongside the entire physician community in support of long-term, meaningful reforms, including an annual inflationary update to Medicare physician payment based upon the Medicare Economic Index (MEI).**

**We have also continued to urge Congress to provide relief from the zero-sum budget neutrality requirements that undermine positive policy changes and hamstring CMS' ability to appropriately pay for all the services a beneficiary needs**. The Academy appreciates that your legislation takes important first steps through proposals such as increasing the budget neutrality threshold to $53 million and at regular intervals thereafter and requiring timely updates to the direct costs used to calculate practice expense Relative Value Units (RVUs).

In addition to already being insufficient, Medicare payments for physician services are adjusted based on the geographic area where a physician works through geographic practice cost indices (GPCIs). Specifically, Medicare will pay more for a physician's service in an area where approximate costs for a physician's time, skills, and effort are higher than the national average and less in an area where costs are lower. This current structure of low payment can prevent rural physicians from being able to feasibly accept as many patients as urban and suburban physicians, further disadvantaging individuals living in those areas and consequently reducing their access to primary care services.

For these reasons, **the Academy strongly supports the elimination of all geographic adjustment factors from the Medicare Physician Fee Schedule except for those designed to achieve a specific public policy goal**, such as encouraging physicians to practice in underserved areas. Congress has previously acted to apply a temporary floor of 1.0 to raise the physician work GPCI value to the national average for localities with values below it. That floor is set to expire on January

20, 2024 without Congressional action, which would result in even greater payment cuts for rural physician practices and undoubtedly jeopardize their ability to stay financially afloat. GPCI floors reduce the geographic variations in Medicare payments, a step toward the elimination of geographic modifiers for which the AAFP advocates.

If we want to do a better job of recruiting and retaining rural physicians, this is one place to start. Patient care provided in a rural area should not be valued less by Medicare than physician work provided elsewhere. Therefore, we applaud that your legislation would provide a one-year extension of the physician work GPCI floor of 1.0 to any locality that would otherwise have an index value below that level. We continue to advocate for the overall elimination of geographic modifiers, but believe this is an important first step.

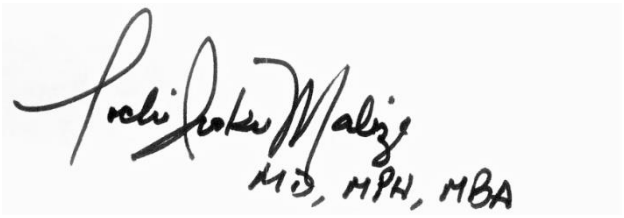
To meaningfully accelerate the transition to value-based payment, the Academy has consistently called for greater federal resources to appropriately support and sustain physician practices moving into APMs. One of these resources has been the incentive payment for practices participating in AAPMs, which was originally enacted at five percent. The AAPM incentive payments have served as an important tool for attracting physicians to participate in AAPMs, which require significant upfront (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the AAPM bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending.

The Consolidated Appropriations Act of 2023 extended the then-expiring incentive payment for an additional year at 3.5 percent. However, the payment is yet again set to expire at the end of 2023 and, if not reauthorized, will institute an additional barrier to continued AAPM participation for physician practices and further impede family physicians' ability to transition value-based payment models.

The expiration of the AAPM bonus poses a broader threat to AAPM participation as physicians may elect to leave an AAPM altogether because they could potentially receive a larger positive Merit-based Incentive Payment System (MIPS) payment adjustment (and would be statutorily excluded from receiving a MIPS adjustment if they were to participate in an AAPM). We appreciate that your legislation at least partially extends the AAPM incentive payment at 3.5 percent for another year.

Thank you for your strong, bipartisanship leadership on the *Physician Fee Schedule Update and Improvements Act*. The AAFP looks forward to working with you to advance policies that will meaningfully reform and strengthen the Medicare program for both patients and physicians. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,




Tochi Iroku-Malize, MD, MPH, MBA, FAAFP

American Academy of Family Physicians, Board Chair

[1] 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Accessed April 6, 2023: https://www.cms.gov/oact/tr/2023