AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

January 5, 2024

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Charles Schumer
Majority Leader
United States Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, D.C. 20510

Dear Speaker Johnson and Leaders Jeffries, Schumer and McConnell:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, we appreciate your commitment during the first session of the 118th Congress to advancing policies to address the existing challenges with physician reimbursement, building and sustaining a strong primary care workforce, and ways to ensure physicians can care for patients with mental health and substance use disorder (SUD) needs within the primary care setting.

As we move into the start of the second session of the 118th Congress and approach the January 19th government funding deadline, we are asking Congress to act on important, time-sensitive items to ensure our patients have access to high quality, affordable, and accessible health care moving forward. This includes:

- **Providing physicians with financial relief from the full 3.4 percent payment cut they are facing in 2024**, without in any way interfering in the implementation of the add-on code known as G2211;
- **Extending both the physician work Geographic Cost Practice Index (GPCI) floor of 1.0 and the advanced alternative payment model (AAPM) incentive payment**;
- **Advancing policies to establish payment parity across care settings**, in addition to passing billing and price transparency requirements to ensure patients can make informed health care decisions;
- **Providing, at a minimum, a multi-year reauthorization of and increased funding for the Teaching Health Centers Graduate Medical Education (THCGME) Program**, as well as for Community Health Centers (CHCs) and the National Health Service Corps (NHSC);
- **Extending the Conrad 30 Waiver Program,** which allows international medical graduates (IMGs) to remain in the United States and care for patients in underserved communities; and
- **Enacting a minor technical fix to ensure trained family physicians can continue to provide necessary care,** including SUD treatment.

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Addressing Physician Reimbursement

In November, CMS finalized the Calendar Year 2024 Medicare Physician Fee Schedule, 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 visits. As of January 1, clinicians are now able to bill G2211. 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 intervene in its implementation, especially now that it is an active code.**

Despite these investments, however, **the AAFP remains deeply concerned that the 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 this year 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]

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). **However, most immediately, Congress must act swiftly and provide physicians relief from the full 3.4 percent payment cuts that went into effect on January 1.** Failure to do so threatens the viability of many physician practices and patients' continued access to care. We urge inclusion of language from the *Preserving Seniors' Access to Physicians Act* (H.R. 6683) in any forthcoming health care package to halt these cuts.

We also continue 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 has supported existing legislative proposals that make incremental but important first steps such as increasing the budget neutrality threshold and requiring timely updates to the direct costs used to calculate practice expense Relative Value Units (RVUs).

Additionally, **any health care package must include extensions of the physician work Geographic Practice Cost Index (GPCI) and the advanced alternative payment model (AAPM) incentive payment.** In addition to already being insufficient, Medicare payments for physician services are adjusted based on the geographic area where a physician works through GPCIs. This creates a structure of low payment that prevents 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. Congress has previously applied a temporary floor of 1.0 to raise the physician work GPCI value to the national average for localities with values below it, but that floor is set to expire on January 20, 2024 without Congressional action.

Meanwhile, 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.

However, the payment expired at the end of 2023 and, if not immediately 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.

Finally, **the Academy strongly applauds recent Congressional efforts to advance policies that will address site of service payment differentials.** We are supportive of the *Lower Costs, More Transparency* (H.R. 5378) provision to ensure payment for physician drug administration services will be the same in an off-campus hospital outpatient department (HOPD) as in a physician's office. We also appreciate the provision in the *Bipartisan Primary Care and Health Workforce Act* (S. 2840) that would prohibit hospitals from charging facility fees for office visits and telehealth services.

The AAFP remains in strong support of site neutral payment policies that would establish payment parity across care settings and has called for an expansion of site neutrality to all on-campus and off-campus hospital-based departments, as well as other facilities. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings and moving services into the hospital or hospital outpatient department setting. Medicare allows hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[2] Advancing site neutral payments is a vital tool for stemming vertical consolidation and reducing beneficiary cost-sharing. It also encourages patient choice based on quality rather than cost. It is the AAFP's policy that patients should have reasonable freedom to select their physicians, other providers, and healthcare settings.

Finally, the Academy appreciates that both H.R. 5378 and S. 2840 seek to advance billing transparency by requiring off-campus HOPDs to use distinct National Provider Identifiers (NPI), as well as codifying hospital price transparency requirements. Improving transparency ultimately provides policymakers, researchers, and other stakeholders with the tools they need to implement meaningful solutions. Understanding the environment that is currently accelerating consolidation and acquisition of primary care practices is essential. Therefore, **we strongly encourage that any final health care package include these provisions to advance site neutral payment and billing and price transparency that will help address misaligned incentives that currently reward consolidation and undermine independent practices.**

Strengthening the Physician Workforce

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes. Despite the significant role that primary care plays in our health system, it accounts for a mere 5-7 percent of total health care spending. Further, it is projected that the country will face a shortage of up to 48,000 primary care physicians by 2034. While the AAFP appreciates recent Congressional efforts to help address health workforce shortages, additional action is needed to comprehensively address the current and projected primary care workforce shortages.

The AAFP recognizes and appreciates work being undertaken by the House Energy and Commerce and Senate Health, Education, Labor and Pension (HELP) Committees to address the physician workforce shortage. The *Lower Costs, More Transparency Act* (H.R. 5378) would reauthorize and

fund the Teaching Health Centers Graduate Medical Education (THCGME) program for an unprecedented seven years. It would extend the Community Health Center (CHC) Fund through calendar year (CY) 2025 at $4.4 billion per year and the National Health Service Corps (NHSC) through CY 2025 at $350 million per year. Family physicians are the most common type of clinician (46%) practicing in CHCs, which provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Increased funding for CHCs is essential to better meet the health workforce needs of the underserved and to increase access to comprehensive primary care in our most vulnerable communities. Important to family physicians, this bill would ensure that patients are paying the same price for a service regardless of the setting where it's provided.

The *Bipartisan Primary Care and Health Workforce Act* (S. 2840) would invest $1.5 billion over the next five years into the THCGME program and establish 700 additional primary care residency slots. Additionally, it includes language to increase the THCGME per-resident allocation (PRA) by $10,000 per year from 2024-2028. It is estimated that these additional opportunities could lead to an increase of 2,800 doctors by 2031. This legislation would also increase funding for CHCs from $4 billion to $5.8 billion per year for three years. Further, it would triple funding for the NHSC to $950 million each year over the next three years, providing 2,100 scholarships and offering debt forgiveness to about 20,000 clinicians who work in vulnerable communities.

The AAFP continues to call on Congress to permanently authorize the THCGME program. The program has trained more than 1,700 primary care physicians and dentists, 63 percent of whom are family physicians. THC graduates are more likely to continue practicing primary care medicine and serving in medically underserved communities than those in Medicare GME–supported programs. Permanent authorization would alleviate the uncertainty caused by short-term reauthorization of the program.

Finally, **the Academy urges Congress to act swiftly and extend the Conrad 30 Waiver Program, which is set to expire on February 2, 2024**. Currently, resident physicians from other countries working in the U.S. on J-1 visa waivers are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 Waiver Program allows these international medical graduates (IMGs) to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Many communities, including rural and low-income urban districts, are facing physician workforce shortages that hinder their ability to meet patients' needs and depend on the physicians in this program to provide health care services. Congress must provide much-needed stability for IMGs and the communities and patients they serve, who remain at risk of losing their trusted, usual source of care if authorization of the program lapses.

Passing the *SUPPORT Reauthorization Act*

The AAFP appreciates the work of the House Energy and Commerce and Senate Health, Education, Labor and Pension Committees in advancing the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Reauthorization Act* (H.R. 4531/S. 3393). Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. They play a crucial role in safe pain management prescribing practices, screening patients for opioid use disorder (OUD), and prescribing and maintaining treatment of medications for OUD (MOUD). Primary care physicians are often the first point of care for patients and can provide necessary referrals or coordinate care with psychiatric and other mental health professionals when needed.

Among the many provisions we support, both versions of the legislation include a minor technical fix to ensure trained family physicians can continue to provide necessary care, including substance use disorder (SUD) treatment. The *Medication Access and Training Expansion (MATE) Act,* passed as part of the *Consolidated Appropriations Act (CAA) of 2023*, included a new requirement that prescribers of controlled substances in schedules II, III, IV, and V complete a one-time eight-hour training before registering or renewing their registration with the Drug Enforcement Agency (DEA). Due to the Substance Abuse and Mental Health Services Administration (SAMHSA) and DEA electing not proceed with statutorily authorized rulemaking, AAFP accredited trainings were not deemed compliant.

The legislative fix (Section 205 in H.R. 531 and Section 403 in S. 3393) **makes a critical technical fix that ensures that family physicians can have access to appropriate training for their specialty and patient population each year** and helps prevent patients from experiencing potential disruptions in their access to ongoing or new care. **Therefore, we strongly urge Congress to include this critical language as part of any health care package.**

Thank you for your efforts on these important issues. The AAFP looks forward to working with you to advance policies that will further recognize the value of primary care for both patients and physicians. Should you have any questions, please contact David Tully, Vice President of Government Relations at dtully@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
Board Chair, American Academy of Family Physicians

Cc:
The Honorable Cathy McMorris Rodgers, Chair, House Energy and Commerce Committee
The Honorable Frank Pallone, Ranking Member, House Energy and Commerce Committee
The Honorable Jason Smith, Chair, House Ways & Means Committee
The Honorable Richard Neal, Ranking Member, House Ways & Means Committee
The Honorable Bernie Sanders, Chair, Senate Health, Education, Labor and Pensions Committee
The Honorable Bill Cassidy, Ranking Member, Senate Health, Education, Labor and Pensions Committee
The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Jim Jordan, Chair, House Judiciary Committee
The Honorable Jerry Nadler, Ranking Member, House Judiciary Committee
The Honorable Dick Durbin, Chair, Senate Judiciary Committee
The Honorable Lindsey Graham, Ranking Member, Senate Judiciary Committee

[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

[2] Pst, B et al. Hospital-physician integration and Medicare's site-based outpatient payments. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.13613