AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance

On

The Markup of the *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act*

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Dear Chairman Wyden and Ranking Member Crapo:

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 both for your bipartisan leadership to address issues impacting family physicians and their patients through today's markup of the *Better Mental Health Care, Lower-Cost Drugs, and Extenders Act*.

Last week, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year 2024 Medicare Physician Fee Schedule (MPFS) final rule, in which they finalized 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. 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% 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, including:

- A statutory freeze on annual Medicare physician payment updates, which is exacerbating already low physician payment rates that have failed to keep up with the cost of inflation – and thus the cost of providing physician services;
- Statutory budget neutrality requirements that require CMS to offset long overdue, urgently needed investments in primary care by lowering the Medicare conversion factor, and therefore payments for every physician service;
- Across the board sequestration cuts that further reduce payments to physicians and other clinicians;
- Expiration of a geographic payment adjustment floor for physician work, which will yield greater payment cuts for rural physician practices;
- Statutory requirements that force CMS to increase the Merit-based Incentive Payment System (MIPS) performance threshold, which CMS estimates will result in a negative payment adjustment for most clinicians in small and medium sized practices, whom patients in rural and other underserved areas rely on for their care; and
- Expiration of the Advanced Alternative Payment Model (AAPM) bonus, which will undermine progress toward value-based payment models that provide clinicians with the support and flexibility they need to deliver better care at lower costs.

Section 407. Increase in Support for Physicians and Other Professionals in Adjusting to Medicare Payment Changes – **The AAFP is sincerely grateful to the Committee for the bipartisan effort to mitigate a portion of the forthcoming payment cuts physicians are facing by providing a 2.5% statutory increase for services furnished under the Medicare Physician Fee Schedule.** However, while this is an important short-term step, it is merely a band aid for a much larger problem. Physician practices cannot weather these annual payment reductions any longer. 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] Congress should heed these warnings.

The AAFP continues to reiterate the urgent need for Congress to prioritize the advancement of necessary, long-term reforms to Medicare's outdated physician payment system that will

address unsustainable fee-for-service (FFS) payment rates for physicians, promote patients' access to high quality, comprehensive primary care, and improve health outcomes.

Physician payment is the only system 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. The Academy continues to advocate alongside the entire physician community in support of legislation that would provide an annual inflationary update to Medicare physician payment based upon the Medicare Economic Index (MEI). We also urge Congress to provide relief from the arbitrary budget neutrality requirements that undermine positive policy changes and hamstring CMS' ability to appropriately pay for all the services a beneficiary needs.

Section 403. Extension of the Work Geographic Index Floor Under the Medicare Program - 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 at the end of this year 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 appreciate the Committee's bipartisan inclusion of 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**, while continuing to advocate for the overall elimination of geographic modifier**.**

Section 404. Extension of Medicare APM Payment Incentives – The Academy has long advocated for the transition to value-based payment and in support of federal policies that would provide appropriate support and incentives to physician practices moving into alternative payment models (APMs) that promote and finance comprehensive, continuous, coordinated primary care. One of these resources has been the incentive payment for practices participating in advanced APMs (AAPMs), which was originally enacted at 5%. The AAPM incentive payments have served as an important tool for attracting physicians to participate in advanced APMs, 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%. 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 MIPS payment adjustment (and would be statutorily excluded from receiving a MIPS adjustment if they were to participate in an AAPM).

The AAFP appreciates that the Committee has proposed to extend the AAPM incentive payment for another year, but we are concerned that a diminished incentive of 1.75% will damage the transition to AAPMs. We strongly urge Congress to extend the AAPM incentive payment at the original 5%.

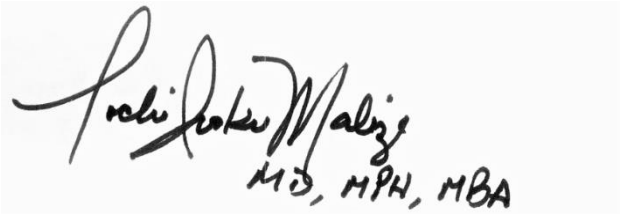
Section 104. Medicare Incentives for Behavioral Health Integration (BHI) with Primary Care - Family physicians provide comprehensive mental health services and are a major source for mental health care in the U.S. Nearly 40 percent of all visits for depression, anxiety, or cases defined as "any mental illness" were with primary care physicians, and primary care physicians are more likely to be the source of physical and mental health care for patients with lower socioeconomic status and for those with comorbidities.[2] 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.

For these reasons, the AAFP has continuously advocated for additional federal investments to initiate and sustain BHI in primary care practices, including resources to support the uptake and adoption of integrated care services such as the Collaborative Care Model (CoCM). **We applaud the Committee's bipartisan work to better support the advancement of these models with the inclusion of this provision, which would temporarily increase Medicare payment for certain integrated behavioral health codes between 2026 and 2028.**

Section 114. Medicaid State Option Relating to Inmates with a Substance Use Disorder Pending Disposition of Charges - The AAFP advocates for individuals who are incarcerated or detained to have access to comprehensive medical services, including mental health care and substance use disorder treatment. We have supported legislation to amend the Medicaid Inmate Exclusion Policy (MIEP) and ensure eligible individuals being detained pre-trial are able to continue receiving substance use disorder (SUD) treatment. The impact of incarceration can begin prior to sentencing as people living in poverty are often incarcerated while pending trial due to their inability to pay the cash bond, regardless of their potential threat to society or severity of their alleged crime. In 2019, 65 percent of people who were incarcerated were awaiting trial.[3] Pre-trial incarceration can last weeks, and sometimes months to years, often disrupting an individual's ongoing SUD treatment and access to care. Therefore, we support the Committee's inclusion of this section to allow states, beginning in 2026, to receive federal payment for medical assistance provided to individuals with SUD who are inmates of a public institution pending disposition of charges.

Thank you again for your continued bipartisan leadership to better support the mental and physical health care needs of Medicare and Medicaid beneficiaries, and the AAFP looks forward to working with you and your colleagues to prioritize meaningful, long-term reforms to Medicare physician payment to improve patients' access to care. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



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Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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[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] Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing Primary Care Contributions to Behavioral Health: A Cross-sectional Study Using Medical Expenditure Panel Survey: Https://Doi.Org/10.1177/21501327211023871
[3] Zeng Z and Minton TD. "Jail Inmates in 2019," U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics. March 2021. Accessed online: https://bjs.ojp.gov/content/pub/pdf/ji19.pdf