inflation. That has made it much harder for

a practical approach, which would help account for inflation. Congress should, at a minimum, pass H.R. 6475, the Physician Update and Improvements Act, that would raise the threshold for implementing budget neutral payment cuts from \$20 million to \$53 million and would provide an increased update to the threshold every five years afterwards based on the MB.

### MACRA Reform Hearings

ACP urges the Committee to convene one or more hearings on the implementation of physician payment policies within the MACRA, which sought to end the antiquated, burdensome and misaligned sustainable growth rate (SGR) payment formula, requiring annual Congressional fixes. We request these <a href="hearings">hearings</a> to focus upon whether the current system achieves the Congressional intent to move towards value-based care and to consider the long-term viability of the current Medicare physician payment system, providing annual updates, meaningful quality measures and predictable outcomes. We have members who are willing to testify as internal medicine represents 24 percent of the physician workforce.

### Medicaid Payment Reform

While <u>84 million</u> Americans receive Medicaid benefits, lower Medicaid payment rates can contribute to <u>negative health outcomes</u>, especially for people of color, and make it harder to access care. Comparatively lower Medicaid payment rates are a substantial factor affecting physician participation in the program. Medicaid payments for services are significantly lower than Medicare payments for the same services. <sup>12</sup>In response, Congress took decisive action and raised Medicaid primary care payment rates to Medicare levels for 2013 and 2014, with the federal government paying the full cost of the increase for the states. Unfortunately, lawmakers failed to reauthorize the payment increase after 2014. The evidence dearly demonstrates that physician participation in Medicaid is tied to reimbursement rates.

Medicare pay parity. Internal medicine physicians commit themselves to a long-term relationship with all their patients, including Medicaid beneficiaries, and furnish first-contact, preventive services and long-term care for complex and chronic conditions that minimizes hospital admissions and other high costs to the health care system. However, increasingly inadequate Medicaid payments impede internal medicine physicians and other dinicians from accepting more Medicaid patients, particularly among small practices, and threatens the viability of practices serving areas with a higher proportion of Medicaid coverage.

### Increasing the Primary Care Physician Workforce Leads to a Healthier Population

Even before the COVID-19 pandemic, the Association of American Medical Colleges (AAMC), estimated that there would be <u>a shortage of 17,800 to 48,000 primary care physicians by 2034</u>. A <u>report</u> by the National Academy of Sciences, Engineering and Medicine calls on policymakers to increase

our investment in primary care as evidence shows that it is critical for achieving quadruple aim (enhancing patient experience, improving population, reducing costs, and improving the health care team experience). Now, with the dosure 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 dinicians serving on the frontlines and increase the number of future physicians in the pipeline.

Evidence clearly shows that increasing the number of primary care physicians (PCPs) helps reduce mortality. A <u>recent study</u> appearing in the *Annals of Internal Medicine* showed that in counties with fewer primary care physicians (PCP) per population, increases in PCP density would be expected to substantially improve life expectancy. People living in counties with only one PCP per 3,500 persons have a life expectancy almost a year less than those individuals living in counties above that level. To reach the one PCP per 3,500 persons ratio in those counties (the Health Resources and Services Health Professional Shortage Areas (HPSA)) would require an

additional 17,651 PCPs, about 15 more physicians per county. To reach a more optimal one PCP per 1,500 people ratio as recommended by the Negotiated Rulemaking Committee convened by HRSA in 2010 would require 95,754 more PCPs or about 36 additional physicians in each of these counties.

Accordingly, Congress should enact policies that will not only increase the overall number of PCPs, but also ensure that these additional PCPs are located in the communities where they are most needed in order to furnish primary care. ACP encourages efforts by federal and state governments, relevant training programs and continuing education providers to ensure an adequate workforce to provide primary care to patients and those continuing to be affected by the pandemic. Funding should be maintained and increased for programs and initiatives that increase the number of physicians and other health care professionals providing care for all communities, including for racial and ethnic communities historically underserved and disenfranchised.

Funding Initiativssional Shortage ArAg Shortage ArAg Shortage Ar

physicians, NHSC members are providing culturally competent care to a target of over 15 million patients at over 18,000 NHSC-approved health care sites in urban, rural, and frontier areas. These

shortage and growing maldistribution.

ACP strongly supports Community Health Centers and has continuously advocated that Congress reauthorize the program's mandatory funding as well as include robust funding in annual appropriations bills. Congress should provide sufficient and continuing financial support for these essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care. For the reauthorization of the CHC program for FY2024 and beyond, Congress should continue its investment and increase funding for CHCs.

We also support expansion of the Medicare Graduate Medical Education (GME) program. ACP was greatly encouraged that bipartisan Congressional leaders worked together to provide 1,000 new Medicare-supported GME positions in the Consolidated Appropriations Act (CAA), 2021, H.R. 133, the first increase of its kind in nearly 25 years, and that some of those new slots have been prioritized for hospitals that serve HPSAs. We encourage Congress to now pass H.R. 2389/S. 1302, the Resident Physician Shortage Reduction Act of 2023, which authorizes 2,000 new GME positions per year for seven years. With an aging population with higher incidences of chronic diseases, it is especially important that patients have access to physicians trained in comprehensive primary and team-based care for adults—a hallmark of internal medicine GME training. It is worth noting that the federal government is the largest explicit provider of GME funding (over \$15 billion annually), with most of the support coming from Medicare.

## Reducing Administrative Burden

Administrative requirements force physicians to divert time and focus away from patient care and can prevent patients from receiving timely and appropriate treatment. They are also a financial burden and contribute significantly to the burnout epidemic among physicians. A 2022 <u>survey</u> of more than 500 doctors from group practices found that 89 percent believe that regulatory burdens increased in the past year, and 82 percent responded that the prior authorization process in particular is very or extremely burdensome.

ACP recommends three ways Congress can help reduce the administrative burden for patients and their physicians. Congress should:

Support Section 301 of H.R. 4822, the Health Care Price Transparency Act. The provision

Advantage (MA) plans establish an electronic prior authorization process to make it easier for

- 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 dinical 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 Independent Primary Care Practices During Consolidation

It is important that Congress offer ways to ensure independent practices remain a viable option in a highly consolidated health marketplace. In our <u>paper</u>

private equity investment, nonprofit hospital requirements, and conversions from nonprofit to forprofit status on patients, physicians, and the health care system. For physician practices, private equity investment and management could alleviate administrative burdens, provide financial stability, and accelerate adoption of health information technology.<sup>3</sup> Research is needed to better understand the effect of private equity investment in health care.

ACP recommends longitudinal resETQq0.00000912000018246 0 612 792s reW\*Anon weW\*nBT3ices/v