On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the subcommittee’s interest in improving patient access to care, minimizing red tape for physicians, and to convey our staunch support for several pieces of legislation before the subcommittee.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. As such, the AOA unequivocally believes that the primary focus of any potential policy or legislative change should be to expand, or at minimum, maintain access to comprehensive high-quality care at the appropriate time and setting. It is with these sentiments that we express our support for the following legislations.

**Patient Access to Care**

The *Saving Access to Laboratory Services Act (SALSA)* is an essential bipartisan, bicameral legislation, which provides critical updates to Medicare’s payment system for laboratory services – supporting earlier disease detection and improved patient care.

Between 2017-2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent. An additional 15 percent cut, for nearly 800 common laboratory tests, is scheduled to take effect January 1, 2024. These drastic payment cuts jeopardize access to many clinical laboratory tests that are used to diagnose, monitor, prevent, and manage common diseases impacting Medicare beneficiaries. The impact of these cuts will be felt hardest by small independent physician practices that offer in-house laboratory services but may no longer be able to sustain such services following further payment cuts. In addition to cuts to the laboratory services, physicians are also facing a payment reduction in the proposed CY24 Medicare Physician Fee Schedule, as the cost of maintaining an independent practice and providing care soars. The closure of these practices because of additional and compounding payment cuts would most significantly impact rural and underserved communities already facing difficulties accessing care.

A strong, national laboratory infrastructure is essential for the rapid development and distribution of tests, particularly for common diseases and new pathogens. The enactment of SALSA would address years of Medicare payment cuts to clinical laboratory services and provide a payment system that is stable and sustainable.
We are also grateful for the subcommittee’s continued efforts to reform prior authorization in the Medicare Advantage (MA) program. The *Improving Seniors Timely Access to Care Act* would help address many of the problems patients and physicians are experiencing in the prior authorization process.

Any change to improve prior authorization should be designed with the end goal of reducing patients’ wait times for treatment, reducing physician administrative burden, and allowing physicians to spend more time with patients. We, therefore, greatly appreciate the Subcommittee’s continued efforts to ensure MA policies are not a barrier to timely and equitable access to care for the patients our members serve. Congress can protect our nation’s seniors from wrongfully delayed or denied care by requiring proper transparency and oversight of prior authorization in the MA program. If adopted, the *Improving Seniors Timely Access to Care Act* will reduce barriers to care, decrease provider burden, and help ensure Medicare beneficiaries enrolled in MA plans have the same access to Medicare-covered items and services as beneficiaries who opt for traditional Medicare.

**Independent Practice Sustainability**

The healthcare system is experiencing unprecedented consolidation, amongst both hospitals and physician practices – contributing to the workforce shortage, and driving up costs, without improving quality of care for patients. For example, in 2020, the Medicare Payment Advisory Commission, or MedPAC, released a report\(^1\) concluding that “the preponderance of evidence suggests that hospital consolidation leads to higher prices.” In addition, a study conducted by the University of Chicago Law School\(^2\) found that physicians in the most concentrated markets throughout the country charged patients 14% to 30% more than practices in the least concentrated markets. Another study that examined Medicare beneficiaries’ patterns of health care utilization found that acquisition of primary care practices by larger hospitals and health systems led to increased utilization and a 5% increase in enrollee spending without considerable changes in quality.\(^3\) Simply put, consolidation does not improve quality of care and drives up costs for patients. It is essential that action is taken to support small and independent practices, and that physicians are able to provide patients with the high-quality care they are trained to deliver, regardless of their practice setting or employment model. In the long-term, comprehensive reform of the Quality Payment Program is necessary to support value-based payment and ensure that providers across settings are treated equitably. However, several short-term actions can provide more immediate, necessary support to physician practices.

The AOA urges the subcommittee to support the passage of the *SURES Extension Act.* The Quality Payment Program’s Small Practice, Underserved, and Rural Support (QPP-SURES) program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access to care while lowering costs. Most small and rural physician practices do not have access to the technical or administrative staff or funding necessary to ensure proper participation in the Merit-based Incentive Payment System (MIPS), which currently disadvantages small and independent physician practices. Research shows that association with large hospital systems and provider networks receive better MIPS performance ratings, despite large health systems not delivering

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demonstrably better quality of care⁴. Physician-owned practices deliver high-quality, cost-effective care regardless of health system affiliation, and this research demonstrates that small and independent practices are being unfairly disadvantaged due to their inability to make the same investments in technical infrastructure and administrative support as compared to larger enterprises.

In addition to funding the QPP-SURS program to provide technical assistance to practices, we encourage the Committee to support practices in making the necessary investments to participate in alternative payment models. For this reason, the AOA strongly supports extending incentive payments for participation in eligible alternative payment models. Ensuring physicians in small and independent practices can participate in payment models that incentivize high-quality, cost-effective care is integral in supporting the physician workforce in our rural and underserved communities.

The Energy and Commerce Committee has said it will review inequities resulting from the area wage index and the geographic practice cost index (GPCI), which is an excellent starting point for review of unique challenges long impacting rural communities. We highly encourage the subcommittee to extend the 1.0 work GPCI floor. According to a 2022 Government Accountability Office report, in 2018, 52 of the 112 payment localities had their work GPCI values raised by the floor to the national average. Without congressional action, the expiration of GPCI floor, established by Congress, will greatly impact rural communities that tend to have more patients in medically underserved areas.⁵

In testimony to the Ways & Means Committee in 2002, Urban Institute economists argued that the GPCI should account for more than just cost of living in order to promote adequate supply of physicians in both urban and rural areas.⁶ Economists recognized at the time that a decision to not include secondary factors impacting the economic feasibility of rural physician practices could damage the sustainability of the rural physician workforce. Equalization of real compensation has not happened in the ensuing 21 years, and rural areas face increasingly severe physician shortages.

The AOA would also like to convey our support for the Provider Reimbursement Stability Act, which would make the following changes to the Medicare Physician Fee Schedule (MPFS) with the goal of promoting sustainability in reimbursement and ensuring continued access to high quality healthcare: (1) increasing the threshold for applying budget neutrality from $20 million to $53 million to reflect the increase in the Medicare Economic Index (MEI) since the threshold was last updated, (2) require CMS to reconcile any overestimates and underestimates of pricing adjustment and make corresponding payment, and (3) updating prices for direct expenses related to budget neutrality adjustments with the goal of more frequently and accurately updating the costs used to calculate the Relative Value Units (RVUs) that are used to calculate the reimbursement formula for physician services.

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⁵ Government Accountability Office. “Information on Geographic Adjustments to Physician Payments for Physicians’ Time, Skills, and Effort.” 2022
In addition to these legislations being considered by the subcommittee, the AOA strongly encourages the committee to consider advancing the *Strengthening Medicare for Patients and Providers Act*, and the *Resident Education Deferred Interest (REDI) Act*.

To address the economic disparities across geographic areas, Congress must implement sustainable adjustments to the MPFS such as tie-ins to the Medicare Economic Index (MEI), which was a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC) for 2024. Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update. This change would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act (H.R.2474)*, and the AOA strongly urges the committee to support this legislation.

**Ensuring a Stable Workforce of Physicians Serving Medicare Beneficiaries**

Substantial student loan debt and year-over-year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. AOA strongly urges the Committee to consider the *Resident Education Deferred Interest Act (REDI Act), H.R. 1202*. The REDI Act would allow resident physicians to defer student loan interest from medical school until the completion of their residency. Medical school graduates must undertake several years of residency with a modest salary and are often unable to begin repaying student debt immediately. While these medical residents are eligible to have payments halted during residency, the debt still accrues interest, causing ballooning balances for many borrowers. The REDI Act would reduce student debt burden without direct forgiveness or reducing the borrower’s original balance.

Reducing the total debt burden for physicians completing residencies would enable physicians to have more flexibility in where they choose to practice. The combined impact of substantial student loan debt and year-over-year cuts to physician payment make it increasingly difficult for new physicians to open their own practices, or to stay afloat as costs rise. In recent years, the ratio of physicians to Medicare beneficiaries has declined among both primary care and specialists. While most Medicare beneficiaries may not currently report acute access challenges, as suggested by MedPAC, this is quickly changing as the Medicare-eligible population grows and the physician workforce does not keep pace.

A recent AAMC report suggests that the physician workforce shortage will grow to between 37,800 and 124,000 physicians by 2034. In light of this looming shortage, it is essential that steps are taken to preserve access to care across the country, especially for Medicare beneficiaries. For this reason, we urge you to support the *Resident Physician Shortage Reduction Act, H.R. 2389*. This legislation would create up to 2,000 new GME slots per year for seven years, prioritizing rural areas, health professional shortage areas, and historically underserved settings, including hospitals affiliated with historically black medical schools. Comprehensive efforts are needed to ensure a stable physician workforce that can care for our country’s growing Medicare population.

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Again, thank you for the opportunity to submit comments for the record. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Congressional Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.