October 4, 2023

The Honorable Jason Smith
United States House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Dear Chairman Smith,

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 thank you for the opportunity to respond to the Ways and Means Committee’s Request for Information on issues impacting the rural health care landscape. This is a particularly important opportunity to provide insight on matters impacting physicians and our patients. Key topics such as geographic payment differences, sustainable provider financing, aligning sites of service, implementing innovative models, and improving the healthcare workforce are uniquely important for the AOA. DOs represent nearly 11% of physicians in the United States but comprise nearly 40% of physicians serving rural and underserved communities. In fact, many osteopathic schools are in rural areas, allowing students to establish connections with these communities at an early stage in their medical education.

Our policy proposals would provide stability in the delivery of high-quality care in rural communities and would provide lasting solutions to problems that have long plagued both patients and physicians across rural America.

**Geographic Payment Differences:**

The Ways and Means 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 disparities long impacting rural communities. **We highly encourage the committee to extend the 1.0 work GPCI floor and permanently extend certain adjustments for cost of practice before it expires at the beginning of 2024.**

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.

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. 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.

To address the economic disparities across geographic areas, Congress must implement sustainable adjustments to the Medicare Physician Fee Schedule (MPFS) such as tie-ins to the Medicare Economic Index (MEI), which

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was a recommendation to Congress by the Medicare Payment Advisory Commission (MedPAC) for 2024.5

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 Ways & Means Committee to consider this legislation further. AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians.

Additionally, the Committee should evaluate proposals such as the bipartisan Rural Physician Workforce Production Act (H.R.834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more feasible.

Sustainable Provider and Facility Financing:
As costs rise and payments decline, it is increasingly unsustainable to open, operate, or improve rural health facilities particularly standalone physician offices. Mitigation – and reversal – of cuts to the Medicare Physician Fee Schedule is the single most important factor to improving the sustainability of rural physician practices. The Physician Fee Schedule is the only part of the Medicare payment ecosystem that does not currently receive any form of annual inflationary adjustment or consideration. This has led to two decades of cuts to physician payment when considering the net impact of payment adjustments against cost increases due to inflation.

Furthermore, Medicare’s current budget neutrality obligations within the physician payment schedule exacerbate the lack of inflationary updates. A provision within the Omnibus Budget Reconciliation Act of 1989 mandated that any adjustments to the MPFS due to upward payments or new procedures in one category that increase costs by $20 million or more must be offset by cuts in other areas of the fee schedule. This issue is reflected in the implementation of a new care complexity add-on code (G2211). Improved payment for longitudinal, coordinated primary care is necessary for physicians, but those payment improvements should not come at the expense of payment reductions in other specialties that would limit the benefits the new code provides.

Additionally, cuts to payments for laboratory services present a unique challenge for rural physicians, as patients will lose access to critical tests if the cuts scheduled to go into effect January 1, 2024, are not addressed. Between 2017 and 2022, payment for common tests for diseases such as diabetes, cancer, and heart disease were cut by 27 percent, and an additional 15 percent cut, for nearly 800 common laboratory tests, will go into effect in the beginning of 2024 without Congressional intervention. These payment cuts will be felt hardest by small, independent physician practices. We strongly urge the Committee to include the Saving Access to Laboratory Services Act (H.R.2377) in a must-pass legislative package before the payment cuts go into effect at the beginning of 2024.

Aligning Sites of Service:
Differences in payment predicated upon the site of service create fundamental inequities in the care delivery landscape, and the MPFS cuts due to go into effect January 1, 2024, would exacerbate existing site of service differences for services that are demonstrably similar. AOA supports policies which would require that payments to physicians reflect the resources necessary to provide high-quality patient care in each setting.

The inequities in the current payment model allows for Hospital Outpatient Departments (HOPDs) to net higher payments for certain services, driving up costs to both Medicare and patients, while driving consolidation
and reducing competition in the care delivery ecosystem. As the Committee considers policies that will align payments for various sites of service, it should prioritize payment models that account for costs incurred to the provider while also taking into account the nature of the patient population being served. Payment policies should also include factors such as the provision of care coordination, after-hours care, emergency care, quality-based payments, and other costs.

MedPAC recommended Congress implement site-neutral payment policies in its July 2023 report, and the AOA strongly echoes that recommendation.⁶

**Health Care Workforce:**
The AOA is grateful for the Committee’s work to tackle physician workforce shortages across the country. The osteopathic profession disproportionately serves rural communities, and osteopathic physicians will play an integral role in addressing patients’ access to care in these communities.

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. Grants and low-interest or interest-free loans for small, rural practices could improve access to the necessary capital to add facilities, rather than contributing to physician consolidation. **AOA strongly urges the Committee to consider the Resident Physician Shortage Reduction Act (H.R.2389).** 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 salary⁷ 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 total debt burden for physicians completing residencies would enable physicians to have more flexibility in where they choose to practice and would allow physicians to make a choice to open their own practices or join an existing physician group in the communities that need them most.

**AOA strongly urges Congress to advance the Substance Use Disorder Treatment and Recovery Loan Repayment Program Reauthorization Act (H.R.4079).** This bill would provide loan repayment for individuals working directly with patients experiencing substance use disorder in Mental Health Professional Shortage Areas. This program is integral to ensuring there is an adequate physician workforce to combat substance use disorder impacting communities.

Beyond these measures, AOA has multiple recommendations to educate, attract, and retain physicians in rural and underserved areas. First, the implementation of an incentive or benefit program for recruiting and retaining physicians in rural and underserved communities. This could be achieved through residency program incentives for physicians who remain in rural and underserved communities following completion of a residency program. Beyond individual incentives for physicians, medical schools and residency programs should be incentivized to support rural health education and training tracks. Similarly, Congress could provide funding increases for Area Health Education Centers. These federally funded, nonprofit programs were created to recruit, train, and retain health professionals in underserved communities, and work regionally to improve quality and access to care.

**Innovative Models and Technology:**
Both rural patients and physicians have been well served by technological advancements and payment flexibilities for care delivery. The expansion of telehealth coverage has allowed physicians to see more patients, and for patients to have better access to the care they need when they need it. Congress can improve access to care by making the availability of telehealth services permanent. Further, the AOA supports the bipartisan Telehealth Expansion Act (H.R.1843), which would improve patient access to telehealth services by allowing first-dollar coverage for beneficiaries with Health Savings Accounts (HSA) and enrolled in a High Deductible Health Plan, which Committee recently passed. Evidence shows that physicians are able to deliver clinically equivalent

⁷ AAMC. “Fellow Stipends and Benefits Survey.” 2022.
care via telehealth for many conditions, increasing the number of patients physicians can see in a given day, and reducing potential access burdens for patients. Additionally, demand for telemedicine remains high post-COVID-19 PHE, especially for mental health services.

Further, the Committee should consider additional funding for the Quality Payment Program’s Small Practice, Underserved, and Rural Support (QPP-SURS) program. This program ensures small and rural physicians can participate in quality payment models that will improve patient outcomes and access while lowering costs. Most small and rural providers do not have access to the technical or administrative staff 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 demonstrably better quality of care. Physician-owned practices deliver high-quality and cost-effective care regardless of health system affiliation, and this research demonstrates the technical and administrative disadvantage small and independent physician practices are currently facing. Ensuring rural physicians can participate in Alternative Payment Models (APMs) that incentivize high-quality, cost-effective care is integral to improving the rural health ecosystem.

Conclusion
Again, thank you for the opportunity to comment on this important Request for Information. The AOA and our members stand ready to assist you as you consider new policies and legislation to improve rural healthcare. 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, at jvillarama@osteopathic.org, or (202) 349-8748.

Sincerely,

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President, AOA

Kathleen S. Creason, MBA
Chief Executive Officer, AOA

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8 Baughman DJ, Jabbarpour Y, Westfall JM, et al. Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System. *JAMA Netw Open*. 2022;5(9):e2233267
9 Kaiser Family Foundation. “Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic.” 2022