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Chicago, IL 60631
Phone: 847.952.5100
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September 29, 2023

VIA ELECTRONIC SUBMISSION

The Honorable Jason Smith
Chairman, Committee on Ways and Means
U.S. House of Representatives
Washington, DC 201515

Dear Chairman Smith:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Ways and Means Committee's request for information (RFI) on solutions aimed at addressing the very real disparities in access to health care that exist for Americans in rural and underserved communities.

ACOFP is the professional organization representing more than 25,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care.

We support Committee's goals in this RFI and are encouraged by your commitment to addressing disparate access to health care. In our comments, we address the following topics: (1) Sustainable Provider and Facility Financing; (2) Health Care Workforce; and (3) Innovative Models and Technology.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

David Park, DO, FACOFP, dist.

David Park, DO, FACOFP, *dist*.
President, ACOFP

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I. Sustainable Provider and Facility Financing

The Committee is requesting comments on policies that support the long-term health of medical providers and facilities to ensure access to care for patients in rural and underserved areas.

a. Proposed Changes to the Medicare Physician Fee Schedule (PFS), Including the Calendar Year (CY) 2024 Conversion Factor

Physicians face an increasingly challenging environment providing Medicare beneficiaries with access to care. Osteopathic family physicians are essential to the nation's public health system and play a critical role in providing care to Medicare beneficiaries. Despite osteopathic family physicians' contributions to patient care and public health, they have been forced to contend with Medicare payments that do not cover the cost of providing care. The failure of the PFS to keep pace with the increasing cost of providing care has created an unstable financial environment for osteopathic family physicians. Many of our members in solo, small, and rural practices have been struggling to remain open. These practices do not have the resources that large physician groups or hospitals have to weather an economic downturn. Also, once a primary care physician office closes in a community, it is very difficult to attract new physicians to serve that community.

In the *CY 2024 PFS and Quality Payment Program* proposed rule, CMS proposes a conversion factor of 32.7476 for CY 2024, which is a 3.36 percent reduction from the prior year. ACOFP opposes this proposed cut because this type of reduction could have a serious financial impact on the ability of osteopathic family physicians to continue practicing and ensuring access to care for patients.

Physicians need financial stability. Many osteopathic family physicians are small-business owners, who are struggling to cope with administrative burdens, pay staff and facility costs, and purchase essential technology. ACOFP therefore urges the Committee to support stable Medicare reimbursement so physicians can provide care to beneficiaries. We strongly support H.R. 2474, the *Strengthening Medicare for Patients and Providers Act*, which would address the rising costs of operating medical practices by providing an annual inflation-based update to the PFS tied to the Medicare Economic Index (MEI).

II. Health Care Workforce

The Committee requests comments on policies to revitalize the health care workforce to improve patient access to care, especially in rural and underserved areas, and specifically requests suggestions for policies that: (1) develop new providers and specialties in areas of the country where shortages are most acute; (2) encourage providers to spend more time on patient care rather than paperwork; and (3) ensure independent practices remain a viable option in a highly consolidated health care marketplace. The Committee specifies that comments should address existing barriers that prevent health care professionals from best providing health care services for patients. Moreover, the Committee requests

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feedback on the adequacy of how graduate medical education (GME) slots are being distributed in rural America.

a. Addressing the Family Physician Shortage Through Compensation and Training

When considering the current health care workforce shortage, it is critical to address the family physician shortage. As more family physicians reach retirement age, the U.S. is facing shortages of 18,000 to 48,000 primary care physicians by 2034.[1] More needs to be done to address this shortage and increase the number of residents choosing family medicine. Significantly higher reimbursement for specialists relative to primary care physicians contributes to the current imbalance between primary and specialty care. Both compensation and training are key tools to address the health care workforce shortage overall, as well as the family physician shortage.

Primary care physicians are poorly compensated relative to their peers in specialty services. A recent study in the compensation trends for primary care and specialist physicians after implementation of the *Affordable Care Act* found that from 2008 to 2017, specialist compensation increased from $378,600 to $399,300 per year, whereas primary care compensation increased, from $214,100 to $247,300 per year.[2] The gap between specialty and primary care salaries remains sizeable.[3] Physician compensation—specifically, the differences in compensation between primary care physicians and specialists—remains a concern that policymakers must address to incentivize physicians to pursue primary care. We support policies that would: (1) equalize reimbursement between various settings of care (i.e., office, outpatient clinic, emergency department) and between family medicine and specialty medical services; and (2) enhance reimbursement by rewarding care that is proven to ensure high-quality patient outcomes and patient satisfaction.

Moreover, medical students are incentivized financially to choose specialty training (e.g., cardiology or pulmonary medicine) over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing, and procedures.[4] Recent efforts to increase Medicare reimbursement for primary care services have been positive steps toward payment equalization. However, a significant reimbursement differential still exists between primary care and specialty care, which neither reflects the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients and to the Medicare program overall. We urge the Committee to consider incentives for medical students to choose family medicine, such as providing financial support for medical education in the form of loans, loan forgiveness, and loan deferment.

b. Distribution of Graduate Medical Education Slots

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[1] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* Association of American Medical Colleges website. Published June 2021. https://www.aamc.org/media/54681/download.
[2] Hsiang WR, Gross CP, Maroongroge S, Forman HP. *Trends in Compensation for Primary Care and Specialist Physicians After Implementation of the Affordable Care Act*. JAMA Netw Open. 2020;3(7):e2011981. doi:10.1001/ jamanetworkopen.2020.11981.
[3] *See id.*
[4] Shi L. *The Impact of Primary Care: A Focused Review.* Scientifica (Cairo). 2012. doi:10.6064/2012/432892.

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We are encouraged by the Committee's attention to the value of Medicare-funded GME slots distributed in rural America and want to emphasize the importance of GME slots for primary care as well. More training opportunities are needed for medical students choosing family medicine, and medical education funding and programs must be preserved and expanded, including the Teaching Health Center GME (THCGME) program and Title VII. Also, while we appreciate the historic increase in GME slots in the *Consolidated Appropriations Act, 2021* and in the *Consolidated Appropriations Act, 2023*, more must be done to fill the provider gap. To meet this need, we urge you to support additional increases in the number of Medicare-funded GME slots and prioritize primary care residency programs to receive these additional slots.

c. Reducing Administrative Burden and Promoting Physician Wellness

We urge the Committee to support policies that will reduce administrative burden, including reducing onerous paperwork requirements across federal programs to allow physicians more time to treat patients. Cumbersome electronic health record (EHR) systems, utilization management policies (such as prior authorization), and continuously changing regulatory rules are forcing physicians to spend more time on administrative tasks rather than on caring for patients. According to recent studies, physicians spend approximately half their time on EHRs and desk work, in addition to completing paperwork after hours.[5] In fact, for every hour a physician spends on clinical time, nearly two hours are spent on EHR and administrative tasks every day.[6] Administrative burden is contributing to the physician shortage and preventing access to appropriate patient care.[7] Many physicians, burned out by paperwork requirements, decide to retire early or leave medical practice for another profession, especially those in small, rural, and solo practices where they do not have the resources to manage all the paperwork requirements.[8] As more of these practices are forced to close or relocate, healthcare shortage areas widen, and more communities lose access to care.

ACOFP also supports federal programs to address physician burnout and promote physician wellness to establish a culture of wellbeing among the physician community. We recognize important steps that have been made to address physician wellness, such as the passage of H.R. 1667, the *Dr. Lorna Breen Health Care Provider Protection Act* which establishes grants to promote mental health and resiliency among health care providers and provides grants for mental and behavioral health training. We urge the Committee to continue developing and supporting policies that promote physician wellness.

d. Recruiting Providers to Rural and Underserved Areas

As described above, rural Americans face poor access to health care. Rural and urban health care disparities have been highlighted since the COVID-19 pandemic, including disproportionately high

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[5] Sinsky C, Colligan L, Li L, et al. *Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties*. Ann Intern Med. 2016;165(11):753–760. doi:10.7326/M16-0961.
[6] *Id.*
[7] *Top Challenges 2021: #1 Administrative Burdens and Paperwork.* Medical Economics website. Published January 15, 2021. https://www.medicaleconomics.com/view/ top-challenges-2021-1-administrative-burdens-andpaperwork.
[8] Freeman L. *Is Your Doctor at Risk?; Burnout Could Drive Physicians from Field, Jeopardize Patient*. Northwest Florida Daily News. Published December 1, 2021.

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incidence and mortality rates in nonurban areas during various periods of the pandemic.[9] ACOFP is committed to treating vulnerable populations, including rural patients, and Congress has a key role in addressing this goal.

We recommend that the Committee support policies that promote the recruitment of physicians in rural areas. For example, ACOFP supports H.R. 834/S. 230, the *Rural Physician Workforce Production Act*, which is designed to promote the training of medical residents in rural areas. As you know, physicians are more likely to practice medicine where they trained so the bill would help ensure a pipeline of physicians in rural areas. We urge the Committee to address the rural physician workforce shortage by supporting the *Rural Physician Workforce Production Act*.

III. Innovative Models and Technology

The Committee is requesting comments on policies to advance innovative care models and technology, especially those that improve access to care in rural and underserved areas. This includes examples of successful models or technology which improve patient outcomes in rural and underserved areas.

a. Increasing Telehealth Access

We strongly support improving broadband and access to telehealth services. Many osteopathic physicians are eager to use telehealth as a way to reach patients in rural areas. However, it is impossible to use telehealth services if the patient (and in some instances, the physician) does not have access to reliable internet. It is critical to expand broadband to all corners of the country. Further, the Committee should advance legislation that would increase access to telehealth by removing regulatory barriers. For example, there are many Medicare reimbursement policies (e.g., geographic and originating site restrictions) that limit the full potential of telehealth.

While we support increased access to technology and broadband for patients who otherwise might not be able to utilize health services, we also want to highlight the importance of existing physician-patient relationships and care coordination. ACOFP believes telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth. We want to ensure equitable access so that patients who might need it most, specifically, those in rural or underserved areas, are able to maximize telehealth opportunities while not sacrificing the physician-patient relationship. In addition, while ACOFP supports the use of telehealth, it is also important to maintain protections to guard against fraudulent activity.

b. Ensuring that Small, Solo and Rural Physician Practices Are Able to Participate in Innovative Care Models

[9] Ullrich F., Mueller K. *COVID-19 Cases and Deaths, Metropolitan and Nonmetropolitan Counties Over Time (update)*. RUPRI Center for Rural Health Policy Analysis Rural Data Brief. Published December, 2022. https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/COVID%20Longitudinal%20Data.pdf.

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A longstanding concern of ACOFP regarding innovative care models that are being tested is the inability of small, solo, and rural physician practices to meaningfully and independently participate in them. Instead, most models being tested by the CMS Center for Medicare and Medicaid Innovation (CMMI) are geared toward large urban practices that have the resources to implement these models. Alternatively, small, solo, and rural physician practices will have to partner with larger entities to participate in such models, thereby sacrificing their independence and becoming a piece of as opposed to the primary driver of health care delivery system reform. Innovative care models should be applicable to urban and rural areas alike and regardless of the size of the physician practice. We therefore urge the Committee to ensure that new care models that are implemented in federal health programs are able to accommodate small, solo and rural physician practices.

As an example, we are encouraged by CMS's recently announced Making Care Primary (MCP) model. However, this model will only be available in eight states, leaving the vast majority of smaller and rural primary care practices without an option to independently participate in an alternative payment model. ACOFP believes greater opportunities should be afforded to primary care practices treating rural and underserved patients given the well-documented value of increased access to primary care services.

We appreciate the opportunity to respond to the Committee's RFI and applaud your efforts in addressing the needs those in rural and underserved communities. ACOFP is ready to work with the Committee on any policy or potential legislation related to expanding access to health care. Thank you for your consideration of our comments.