AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 28, 2021

The Honorable Richard Neal
Chairman
House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Terri Sewell
Co-Chair, Racial Equity Initiative
House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jimmy Gomez
Co-Chair, Racial Equity Initiative
House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Steven Horsford
Co-Chair, Racial Equity Initiative
House Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Re: Racial Equity Initiative Recommendations for the American Jobs and Family Plan

Dear Chairman Neal and Representatives Sewell, Gomez, and Horsford:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 133,500 family physicians and medical students across the United States, we write to support the Racial Equity Initiative's recommendations highlighted below for the American Jobs and Family Plans.

The AAFP advocates for federal policies and programs to advance health equity and ensure family physicians can provide comprehensive, continuous primary care to all patients, including those who are historically underserved and systematically disadvantaged. As trusted members of their communities, family physicians are uniquely positioned to address patients' medical and social needs and enable them to achieve health and wellbeing. As such, we have urged family physicians to become informed about how social determinants of health, systemic racism, and other factors impact patients' health, as well as identify tangible next steps they can take to reduce health inequities.

We also have adopted a Health in All Policies strategy to acknowledge that policy decisions made at all levels directly affect the health of individual patients and communities by influencing the social and economic factors that drive the social determinants of health.

Infrastructure – Broadband

The AAFP supports federal investments to increase broadband access, particularly in rural and underserved communities. The COVID-19 pandemic has highlighted how disparate access to broadband, smartphones, and other digital devices and infrastructure can exacerbate existing health and financial disparities. Millions of Americans rely on broadband and technology devices to access preventive health services, mental and behavioral health care, education, job and housing resources, and public health information. However, at the end of 2019, more than 14.5 million Americans lacked access to broadband at the recommended speed of 25/3 Mbps.[1] Without broadband, many individuals living in Tribal, rural, and urban areas are unable to connect with their physicians via telehealth to receive needed care. When combined with policies that improve the affordability of and

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access to health care services, improved broadband access can advance heath equity and remove other barriers to care like transportation or childcare Broadband access also addresses other social needs like education, safe housing, employment, and applying for public programs that provide financial assistance and health insurance. However, since broadband availability continues to be disparate, federal policies should be designed to ensure equitable access and reduce disparities.

Health and Economic Equity - Health Care Coverage Expansion
The Academy recognizes health as a basic human right for every person regardless of social, economic or political status, race, religion, gender or sexual orientation. The right to health includes universal access to timely, high quality, and affordable essential health care services.

The AAFP supported the COBRA subsidies and expanded premium tax credits in the American Rescue Plan as important short-term steps to help more Americans access insurance during the pandemic. While these policies reduced insurance premiums and reduced the number of uninsured individuals, they unfortunately do not guarantee affordable access to health care. More than 30 percent of people with employer-sponsored health coverage are enrolled in high-deductible health plans (HDHPs).[2] The large deductibles associated with these plans are becoming an increasingly problematic hurdle to obtaining health care, particularly as Americans struggle financially as a result of the pandemic. According to a survey, 68 percent of adults said that out-of-pocket costs would be very or somewhat important in their decision to get care if they had symptoms of the coronavirus.[3] Additionally, 40 percent of Americans do not even have $400 to cover unexpected expenses, implying that high deductibles limit access to services that are deemed critical for patients' well-being.[4] HDHPs compound access problems and ultimately lead to worse health outcomes, especially for low-income Americans and those with chronic conditions. In addition to the pandemic itself, the COVID-19 recession has hit people with low incomes and people of color especially hard.[5] During the last recession, both black and Hispanic people saw a disproportionate increase in the share of people unable to access needed care due to cost.[6] **To help alleviate cost barriers to care and avoid worsening access disparities, Congress should pass legislation to allow HDHPs to waive the deductible for critical primary care services.**

The AAFP supports policies to expand Medicaid coverage for at least one year for postpartum women, and supports expanding Medicaid eligibility as a path to make health care available to all by increasing access to care. Medicaid plays a particularly vital role in providing coverage to pregnant individuals, rural residents and individuals with disabilities, as well as Black, Indigenous, Hispanic and other people of color. More than 30% of Black, Indigenous and Hispanic adults and children have Medicaid coverage.[7] By improving coverage and the affordability of primary care, the ACA significantly reduced racial and ethnic disparities in care utilization and access. However, the odds of being in a physician shortage area are much higher for predominantly Black neighborhoods.[8] Sixty-one percent of Primary Medical Health Professional Shortage Areas (HPSAs) are also in rural areas, suggesting that these populations may be impacted most by changes in Medicaid physician participation.[9] On average, a clinician treating a Medicaid enrollee is paid about two-thirds of what Medicare pays for the same service and, in some states, as little as one-third. Low Medicaid physician payment rates have historically been a barrier to health care access for enrollees.[10] Physicians cite low reimbursement as the primary reason they are unable to accept additional Medicaid patients.[11] Patients covered by Medicaid experience longer office wait times, and both low-income patients and their physicians report that low reimbursement rates lead to shorter, inadequate visit times.[12] **Increasing Medicaid rates for primary care services would help to mitigate health inequities.** The AAFP urges Congress to pass the Kids Access to Primary Care Act (H.R.1025) to ensure that current and future Medicaid beneficiaries have timely access to the high-quality care they need.

We continue to advocate for meaningful and affordable health care coverage and stand ready to work with the Committee to further build on the Affordable Care Act's successes and further improve our health care system.

Health and Economic Equity – Physician Workforce

Physician Workforce Diversity
The AAFP is dedicated to developing a family medicine workforce as diverse as the U.S. population. Family physicians are more geographically diverse than any other medical specialty, practicing in urban and rural underserved communities across the country. While primary care specialties lead other specialties in representation of racial and ethnic minorities in the workforce, the entire medical workforce lags significantly behind the racial and ethnic diversity of the U.S. population.

Increasing diversity in the physician workforce is critically important for culturally competent care, access to care for traditionally underserved populations, and effective clinical and health services research efforts.[13] Studies show underrepresented minority physicians are more likely to practice in underserved and low income areas.[14] Black physicians saw six times as many Black patients, and Hispanic physicians saw three times as many Hispanic patients compared to non-Black and non-Hispanic physicians, respectively.[15] Moreover, when physicians and patients share the same race or ethnicity, there is a greater likelihood of shared decision making, trust, and participation in preventive services.[16]

A more representative pipeline for the physician workforce can and should begin well before a student enters medical school. Given the federal government's role in funding graduate medical education, there are many policy and programmatic levers it can use to diversify the physician workforce. Specifically, it is vital that the federal government expand and sustain residency training opportunities in underserved and low-income areas.

Strengthen the Physician Pipeline
The AAFP has made several recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding distribution of the one thousand additional Medicare GME residency positions that Congress passed last year. We urged CMS to consider an additional "impact factor" when evaluating applications for new residency slots to prioritize those hospitals or programs that have the highest proportion of trainees that ultimately go on to practice in health professional shortage areas (HPSAs). Ensuring an equitable and effective distribution of GME positions is vital for increasing training opportunities in community settings and improving access to primary care for underserved populations.

Health and Economic Equity – Medicare Data Collection
Addressing health inequities requires a full and accurate view of existing disparities. Currently, most health data collection efforts at the federal, state, and local level are focused on five broad racial groups, two ethnicities, and variable descriptors for LGBTQ+ people. Without specific indicators, these populations may not receive adequate consideration in budgeting processes and resource allocations, resulting in further disadvantage. The AAFP supports collecting more detailed data that includes specific ethnic groups within each race based upon broader similarities such as country/continent of origin, language, and religious background, and sexual orientation and gender identity including individuals who are lesbian, gay, bisexual, and/or transgender. These more detailed groups should be standardized for use across health care stakeholders. The AAFP has also urged ONC to continue its work with EHR vendors to ensure new standards are incorporated into existing platforms without imposing additional costs on physician practices.

As data collection becomes more specific, it is vital that aggregate data sets protect patients' confidentiality. Additionally, all aggregated data should be easily accessible by physicians and administrators, particularly for those in community-based settings. Aggregate datasets that can be accurately stratified by race and ethnicity, as well as sexual orientation and gender identity, are vital tools for physician practices and health care organizations to identify disparities within their patient panel and work to address them. The same is true for data collection and reporting for public health purposes.

Health and Economic Equity – Telehealth

Telehealth benefit expansions must increase access to care and promote high-quality, comprehensive, continuous care. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care and expand access to care for under resourced communities. As we stressed in our testimony for the Ways and Means Committee's recent telehealth hearing, the AAFP believes that any telehealth benefit expansion should enhance the physician-patient relationship rather than disrupt it, and incentivize coordinated, continuous care provided by the medical home.

As Congress considers whether to extend the telehealth flexibilities beyond the public health emergency and how to build upon recent advances, it is vital that Medicare and Medicaid policy changes are designed to advance health equity, protect patient safety, and enable clinicians to provide the right care at the right time. At a minimum, the AAFP urges Congress to monitor the impact of telehealth on access and equity by ensuring that further data collection include race, ethnicity, gender, language and other key factors.

The AAFP commends your actions to address disparities and improve equity. We stand ready to work with the Committee as Congress continues to work toward a final infrastructure package. Should you have any questions, please contact Erica Cischke, Senior Manager of Legislative and Regulatory Affairs, at ecischke@aafp.org.

Sincerely,

Gary L. LeRoy, MD, FAAFP

Gary L. LeRoy, MD, FAAFP
Board Chair
American Academy of Family Physicians

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[1] FCC Annual Broadband Deployment Report Shows Digital Divide Is Rapidly Closing. FCC. Pub. January 19, 2021. https://docs.fcc.gov/public/attachments/DOC-369393A1.pdf

[2] Basu, D. B. (2020, June 18). A Scalpel Instead of a Sledgehammer: The Potential Of Value-Based Deductible Exemptions In High-Deductible Health Plans: Health Affairs Blog. Retrieved January 22, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20200615.238552/full/

[3] Collins SR, Gunja MZ, Blumenthal D, et al. What are Americans' views on the coronavirus pandemic? NBC News/Commonwealth Fund health care poll. Published March 20, 2020. Accessed January 22, 2021. https://www.commonwealthfund.org/publications/surveys/2020/mar/what-are-americans-views-coronavirus-pandemic

[4] Board of Governors of the Federal Reserve System. Report on the economic well-being of US households in 2018. Published May 2019. Accessed January 22, 2021. https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf

[5] https://www.pewsocialtrends.org/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/

[6] https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and#_ftn16
[7] "Medicaid Coverage Rates for the Nonelderly by Race/Ethnicity." *Kaiser Family Foundation,* 2019. https://www.kff.org/medicaid/state-indicator/nonelderly-medicaid-rate-by-raceethnicity
[8] Brown, E, Polsky, D, Barbu, C, Seymour, J, Grande, D. "Racial Disparities in Geographic Access to Primary Care in Philadelphia." *Health Affairs,* Aug 2016. https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1612
[9] "First Quarter of Fiscal Year 2021 Designated HPSA Quarterly Summary." *Health Resources and Services Administration Bureau of Health Workforce,* 31 Dec 2020. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[10] Cohen, JW. "Medicaid physician fees and use of physician and hospital services." *Agency for Health Care Policy and Research, U.S. Department of Health and Human Services,* Inquiry. vol. 30, no. 3, 1993, pp. 281-92. PMID: 8406785. https://pubmed.ncbi.nlm.nih.gov/8406785/
[11] Decker, SL. "In 2011 nearly one-third of physicians said they would not accept new Medicaid patients, but rising fees may help." *Health Aff (Millwood),* vol. 31, no. 8, 2012, pp. 1673-9. doi: 10.1377/hlthaff.2012.0294. PMID: 22869644; PMCID: PMC6292513. https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.0294
[12] Lewis, C, Zephyrin, L, Abrams, M, Seervai, S. "Listening to Low-Income Patients and Their Physicians: Solutions for Improving Access and Quality in Primary Care." *Commonwealth Fund,* 15 May 2019.5 https://www.commonwealthfund.org/blog/2019/listening-low-income-patients-and-their-physicians--improving-access-and-quality
[13] Cohen JJ, Gabriel BA, Terrell C. The Case For Diversity In The Health Care Workforce. Health Aff (Millwood). 2002;21(5):90-102. doi:10.1377/hlthaff.21.5.90
[14] Goodfellow A, Ulloa JG, Dowling PT, et al. Predictors of Primary Care Physician Practice Location in Underserved Urban and Rural Areas in the United States: A Systematic Literature Review. Acad Med J Assoc Am Med Coll. 2016;91(9):1313-1321. doi:10.1097/ACM.0000000000001203
[15] Komaromy M, Grumbach K, Drake M, et al. The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. http://dx.doi.org/10.1056/NEJM199605163342006
[16] Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. JAMA. 1999;282(6):583-589. doi:10.1001/jama.282.6.583