AMERICAN ACADEMY OF FAMILY PHYSICIANS

October 9, 2019

Thomas J. Engels, Acting Administrator
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Acting Administrator Engels:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the "Rural Access to Health Care Services Request for Information" posted by the Health Resources and Services Administration (HRSA) in August of 2019.

**The AAFP appreciates that HRSA issued this request for information since we agree rural areas face particular challenges related to accessing health care services**. Seventeen percent of our members practice in rural communities which is the highest percentage of any specialty. Many provide obstetrical care and emergency medical services under some of the most challenging conditions possible. Recognizing the challenges in rural health, the AAFP recently launched Rural Health Matters, an Academy-wide strategic initiative to improve health care in rural communities. Through this initiative, the Academy seeks to:

- Develop and implement an integrated AAFP rural strategy;
- Establish the AAFP as a leader for rural health and rural physicians;
- Influence policy and payment issues related to rural health;
- Address educational needs and resources for family physicians practicing in rural areas;
- Support recruitment of family physicians to rural areas, including by increasing student choice, the number of residency positions and support for residency programs; and
- Create policy, collaboration and resources to help family physicians improve rural health disparities.

**The underlying reasons for rural health care crisis are multifactorial but include lower payments family physicians receive under Medicaid, the closure of many rural hospitals, the impact of hospital and insurance consolidation, greater impact of poorly functioning, high-cost electronic health records on solo and small independent practices, and the poor recovery of rural communities after the economic downturn.**

This is not to say inner-city underserved patients are not also in crisis, only that the health care situation in rural America is dire and has the potential to become much worse. The solutions to the rural health care crisis are also relevant to inner-city underserved patients. These two populations share many problems with care access and delivery. Family physicians practicing in these locations share issues with payment, workforce and scope of practice. The AAFP recognizes solutions for rural communities will also benefit inner-city underserved communities.



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The AAFP's rural initiative work also overlaps with the work of the AAFP Task Force on Maternal Morbidity and Mortality. One area in which these task forces are charged with is addressing the growing loss of rural maternity services nationwide.

Regarding advocacy, the AAFP calls for funding for teaching health centers, which we see as not only important for developing the family physician workforce the nation needs, especially in rural communities, but also providing needed care in those communities. In addition, the AAFP advocates for removal of funding caps for hospitals that have had a previous rotating resident. **We have vehemently argued that rural health care must be paid at a higher level, and that new payment models must take rural family physicians' practices into account. In the AAFP's 2017 Value-based Payment Study, 70% of respondents indicated lack of staff time as a barrier to implementing value-based care, while 41% indicated the financial investment required for health IT is a barrier. Specifically, among practice owners, 74% cite lack of staff time, and 52% cite financial investment as barriers to implementing value-based care. These barriers are amplified for rural practices as inadequate payment and lower volume make it difficult to subsidize needed investments.**

The AAFP offers the following feedback to the questions posed by HRSA to help determine how to deliver care in rural areas in a sustainable manner and how rural health care may change in the future to ensure that it is accessible, high quality, value-based, and provided at the lowest cost possible.

1. What are the core health care services needed in rural communities and how can those services be delivered?

HRSA must ensure that rural communities have access to maternity, emergency, and primary care services across generations. All of these services can be provided by well-trained family physicians. Even in poorly resourced communities, a core group of family physicians can provide much of the care found in tertiary care hospitals, especially in conjunction with technologic and system advances such as telemedicine.

Every community should have a plan for addressing obstetric, pediatric, and traumatic emergencies, though the details will vary significantly based on distance to tertiary care, weather, and community capabilities.

Specialties other than family medicine can provide greater depth of care. Non-physician providers can extend care and increase access. Nonetheless, family physicians must be the core of the rural safety net. Primary care services are best delivered by family physicians. Through their education and residency training, family physicians possess distinct attitudes, skills, and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of gender, age, or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters, including the appropriate use of consultants, health services, and community resources.

Family physicians are the rural safety net. They provide obstetrical care and emergency medical services under some of the most challenging conditions possible. The AAFP urges HRSA to recognize and align core health care services with the AAFP definition of "primary care", which is:

> *Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.*
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> *Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.*

According to data from the AAFP, rural family physicians (83%) are more likely to accept new Medicaid patients compared to urban physicians (67%). **To improve the delivery of care in rural areas, we implore HRSA, the Department of Health and Human Services (HHS), and its Rural Health Task Force to advocate for urgent state and federal efforts to raise Medicaid physician payment levels to at least Medicare rates for services rendered by a primary care physician.** Payment rates in Medicaid are seriously low, especially for primary care services. Nationwide, Medicaid payment is 66 percent of Medicare for primary care services and can be as low as 33 percent of Medicare rates depending on the state. Lack of parity between these rates has disproportionately impacted access for rural, low-income, disabled, and elderly Medicaid enrollees, as many physicians are unable to afford new Medicaid patients due to low payment rates.

2. What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?
Rural communities are heterogenous and their needs vary community to community. HRSA will need to study rural communities through a lens that allows differentiation of needs from one location to another due to local population needs, documented disparities, age of the population, and availability of technology and human resources.

For smaller communities, a core family physician group can provide robust care while minimizing physician burnout from excessive on-call duties and lack of sleep. Patient to physician ratios may need to be adjusted for smaller communities to allow this core group to practice. With larger populations, more specialization and non-physician practitioners may become possible.

The AAFP encourages HRSA to examine where family physicians practice in the United States. HRSA must support recruitment of family physicians to rural areas, including by increasing student choice, the number of residency positions, support for residency programs, and funding to sustain existing and develop new rural training tracks for graduate medical education (GME). The AAFP encourages HRSA to review a detailed annotated bibliography developed by the Robert Graham Center to inform policy discussion and future publications regarding the widening gap of healthcare disparities and outcomes, the distribution of the physician workforce in rural America, and the current GME system financing. Specific areas of research include the disproportionate distribution of GME financing as well as innovative policies enacted to reduce these disparities.

3. What other factors are important to consider when identifying core health services in different rural communities, such as current and projected population size, distance to the nearest source of care, availability of telehealth, and sustainability of services?
We encourage HRSA to examine network adequacy as a factor in identifying core health services in rural communities. Strong network adequacy standards promote the primary care medical home model as a way to deliver higher quality, lower costs, and a stronger patient-physician relationship. A recent study in *JAMA Internal Medicine* reported that the supply of primary care physicians is associated with lower mortality rates. This suggests that the supply of primary care physicians impacts population health. Primary care capacity should be the focal point of network adequacy and HRSA should examine the percentages of family physicians and other primary care physicians participating in rural areas. Additionally, when determining network adequacy, the ratios for primary care physicians to covered persons and for physicians to covered persons by specialty, should reflect physician FTEs, because physicians may practice part-time or in multiple locations. In addition, non-physician providers (i.e., nurse practitioners and physician assistants) should not be counted because listing these providers creates the illusion that there is more access to physicians.

Since rural communities are heterogeneous and needs vary, we again urge HRSA to differentiate each community's needs. Other factors important to consider are distances to nearest hospitals, transportation options, availability of community services, and the community's infrastructure including the quality of the roads and availability of IT support services, especially internet access. The AAFP encourages HRSA to utilize the Rural Health Explorer developed by HealthLandscape, an interactive web-based mapping tool that allows policy makers to explore rural health and healthcare by combining workforce, health determinants, health outcomes, and links between the two. The UDS Mapper, funded by HRSA/BPHC and developed by HealthLandscape, also can be used to identify existing services and service needs by combining HRSA's UDS data of health center utilization with data including existing health care facilities, population demographic and health-related metrics including small-area chronic conditions, as well as medication-assisted treatment (MAT) centers related to the ongoing opioid epidemic.

4. How should we measure access to health care services in rural communities? What are the best ways of measuring quality of care in rural communities?
HealthLandscape, working with the Scope of Practice Partnership (a collaborative effort of the AAFP, the American Medical Association, American Osteopathic Association (AOA), national medical societies, state medical associations and state osteopathic medical associations), has developed a detailed Health Workforce Mapper which allows policymakers to visualize the geographic distribution of physicians and non-physician clinicians in rural and non-rural areas.

The HealthLandscape tools should be used to measure access to health care services in rural communities. The HealthLandscape team is dedicated not only to data democratization and data visualization, but also to research related to health, health care and social determinants of health.

The AAFP cautions against penalizing primary care physicians in rural areas where there is low or limited access in accepting new patients since there are multiple factors in the physician-supply chain outside the control of a practicing physician.

Performance measurement programs and associated measures require that the organization being measured have control over the dimensions involved. Lack of control over significant factors in rural America negatively impact the ability of rural physicians to perform well on many existing

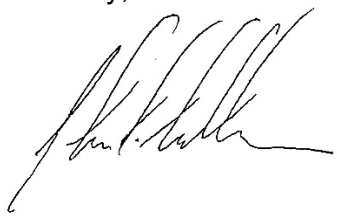
performance measures. Factors such as shortage of primary care physicians, lack of specialists (especially behavioral health specialists), transportation, high Medicaid and uninsured populations, cultural issues, closure of emergency rooms and obstetrical services, among others lead to extremely challenging conditions for the rural family physician. We encourage CMS to use performance measures to help identify gaps in services and outcomes at the community and population levels and use this information to allocate resources to improve equity, access, and socioeconomic factors that impact health and health care. Such measures should not lead to financial penalties for low performance as penalties simply exacerbate an already difficult situation.

We encourage CMS to pursue a strategy for quality reporting in rural settings that is similar to existing policy that applies to Rural Health Clinics. This would require assessment and a quality improvement plan but would not require reporting of quality measures. Quality improvement efforts require transparency and a safe space to allow honest assessment of care without fear of punishment and without pressure to increase revenue or produce bonus payments. Physicians must have a leadership role in QI efforts, with patients, clinical teams, and community partners as key players. Ideally, assessment would take place at the community level. Each community's quality measures would be selected based on services offered, importance to patients and health care professionals, needs of the community being served, and perceived or identified gaps in care. On their own, individual health care professionals have limited ability to drive outcomes in health and health care and are constrained by the environment and systems in which they practice. A community-level approach supported by data generated from CMS, payers, Health Landscape, pharmaceutical databases, and other existing data sources has greater potential of accelerating improvement than does the existing structure of MIPS reporting.

Finally, we urge HRSA to consult the AAFP policy on "Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models" in determining proper measurement and assessment of health care services in rural communities. This policy provides suggestions for how payment models should account for social determinants of health in their methodologies. We encourage policymakers to review this policy to create similar structures and incentives to motivate and enable practices to address social determinants of health.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 or rbennett@aafp.org with any questions.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair