AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance
Subcommittee on Health Care

On

Improving Health Care Access in Rural Communities: Obstacles and Opportunities

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Dear Chairman Cardin and Ranking Member Daines:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write to applaud the Subcommittee for its focus on rural health care with today's hearing titled "Improving Health Care Access in Rural Communities: Obstacles and Opportunities."

Individuals living in rural areas face significant barriers and challenges to accessing high-quality, comprehensive health care. Rural hospitals have closed at an alarming rate over the last ten years, and many rural populations face long travel times for primary and emergency care. Additionally, while many patients benefited from new telehealth flexibilities due to the COVID-19 public health emergency (PHE), rural individuals were less likely to have broadband access and therefore less likely to connect via video for virtual visits.[1]

The AAFP has long advocated to improve access to high-quality care in rural communities. Seventeen percent of our members practice in rural areas, the highest percentage of any medical specialty. Family physicians are uniquely trained to provide a broad scope of health care services to patients across the lifespan. This enables them to tailor their practice location and individual scope of practice to the needs of their communities. As a result, family physicians are an essential source of emergency services, maternity care, hospital outpatient services, and primary care in rural areas. It is with these considerations in mind that we offer the following policy recommendations to improve health care access in rural communities.

Physician Payment Reform

Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates and the continuing consolidation of insurers and large health systems threatens their long-term viability, especially in rural communities. Evidence indicates that consolidation increases health care prices and insurance premiums, as well as worsens equitable access to care for patients in rural and other medically underserved communities.[2,3]

Medicare's current physician payment system is undermining physicians' ability to provide high quality, comprehensive care – particularly in primary care. Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices and undermine patient care. In October, the AAFP submitted robust recommendations to Congress on ways to reform the Medicare Access and CHIP Reauthorization Act (MACRA) to address challenges affecting our members and their patients. Since then, both Medicare Payment Advisory Commission and the Board of Trustees have raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending that Congress provide payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[4]

Congress should heed these warnings. **The AAFP strongly urges Congress to pass the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to provide for an annual update to the Medicare Physician Fee based on the Medicare Economic Index (MEI).** This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries.

In addition to already being insufficient, Medicare payments to physicians are generally less in rural areas than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and

suburban physicians, further disadvantaging individuals living in rural areas and consequently reducing their access to primary care services. For this reason**, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal** (e.g., to encourage physicians to practice in underserved areas).

Medicaid also plays an invaluable role in connecting many rural individuals to health care coverage. In 2018, nearly 25 percent of rural residents under 65 were on Medicaid and more were dually-enrolled in Medicare and Medicaid.[5] However, lack of parity between Medicaid and Medicare payment rates disproportionately impacts access for rural, low-income, disabled, and elderly Medicaid enrollees, as Medicaid payments fall below the actual cost of delivering care in those areas. On average Medicaid, pays just 66 percent of the Medicare rate for primary care services and can be as low as 33 percent in some states.[6] This reduces the number of physicians who participate in Medicaid and limits access to health care for children and families. Increasing Medicaid payment rates will improve access to care for Medicaid patients, lead to better health outcomes, and reduce longstanding health disparities. **The AAFP urges Congress to pass the Kids' Access to Primary Care Act of 2023 (H.R. 952) to permanently raise Medicaid payment rates for primary care services to at least Medicare levels.**

Strengthen and Target Graduate Medical Education Programs

Most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.[7] As a result, the current distribution of trainees leads to physician shortages that are particularly dire in medically underserved and rural areas. While 20 percent of the U.S. population lives in rural communities, only 12 percent of primary care physicians and eight percent of subspecialists practice in these areas.

Teaching Health Centers (THCs) play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the Teaching Health Center GME (THCGME) program has trained more than 1,730 primary care physicians and dentists, 63 percent of whom are family physicians. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities. This demonstrates that the program is successful in tackling the issue of physician maldistribution and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

The THCGME program's authorization expires in FY 2024, and we strongly caution against a short-term extension since it does not provide the needed stability for current and future residents. In fact, flat funding of the program would mean a 40-50 percent reduction in per resident allocation for THC programs, putting them at risk of closure. **Congress should permanently authorize and expand the THCGME program by passing the Doctors of Community Act (H.R. 2569).**

We also strongly urge Congress to pass the Rural Physician Workforce Production Act (S. 230 / H.R. 834), which would provide invaluable new federal support for rural residency training to help alleviate physician shortages in rural communities. Specifically, the bill would remove caps for rural training and provide new robust financial incentives for rural hospitals, including critical access and sole community hospitals, to provide the training opportunities that the communities they serve need.

While the new Medicare GME residency slots approved in the previous Congress were very much appreciated, additional action is needed to address disparate access to care in rural and other

medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need**, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare as the largest single payer – spends about $16 billion annually on GME – but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[8] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.

Federal Programs to Support Physicians in Rural Areas

International Medical Graduates (IMGs) have a significant impact on addressing health care clinician shortages and improving access to care in rural communities. The Conrad 30 Waiver Program has brought more than 15,000 foreign physicians to underserved and rural communities. The program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients at a time when pervasive workforce shortages continue to restrict patients' access to necessary care. **We urge Congress to pass the Conrad State 30 & Physician Access Act (S. 665) to provide immigration certainty to the thousands of international medical graduates caring for patients in underserved communities.**

The National Health Service Corps (NHSC) also plays a vital role in addressing the challenge of regional health disparities arising from physician workforce shortages by offering financial assistance to meet the workforce needs of communities designated as health professional shortage areas. **We urge the reintroduction and passage of the Strengthening America's Health Care Readiness Act**, which increases investment in the National Health Service Corps and allocates 40 percent of the funding for racial and ethnic minorities and students from low-income urban and rural areas.

Strengthen and Sustain the Health Care Safety Net

Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) provide comprehensive primary care and preventive services to some of the most vulnerable and underserved Americans. Family physicians are the most common type of clinician (46 percent) practicing in CHCs, and thus are well-positioned to ensuring accessible and affordable primary care and reducing racial, ethnic, and income-based health disparities.[9] CHCs also play an important role in training family physicians, and research shows that CHC-trained family physicians are more than twice as likely to work in underserved settings than their non-CHC-trained counterparts.[10] **The AAFP urges Congress to increase investment in CHCs**, including a long-term authorization for CHCs, to meet the health workforce needs of the underserved and to increase access to comprehensive primary care in rural communities.

Telehealth

Permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs. As acknowledged earlier, the lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban

counterparts, leading to fewer audio/video visits.[11,12,13] One recent study of FQHCs found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[14]

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Congress should implement policies that strengthen patients' relationships with their primary care physician, and physicians should not be paid less for providing patient-centered care. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

The AAFP strongly urges Congress to pass the Protecting Rural Health Access Act (S. 1636 / H.R. 3440), which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services. The available data clearly indicates that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after the PHE-related telehealth flexibilities expire.

This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which the AAFP has advocated to Congress in favor of previously. The COVID-19 pandemic has demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

Finally, the Protecting Rural Telehealth Access Act would permanently allow RHCs and FQHCs to serve as distant site for telehealth services. As noted above, FQHCs and RHCs are essential sources of primary care for patients in underserved communities, including low-income individuals and those living in rural areas. During the pandemic, FQHCs and RHCs have made significant investments to integrate telehealth into their practices and ensure equitable access to telehealth services for their patient populations. Passing this bill would ensure these facilities can continue to provide telehealth services, improve equitable access to health care for historically underserved patients, and preserve care continuity with their primary care physicians.

Access to Mental and Behavioral Health

The AAFP has continuously advocated for and supported legislative proposals to permanently remove CMS' in-person requirement for tele-mental and behavioral health visits. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[15,16] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients, which are even more pronounced in rural areas. Arbitrarily requiring an in-person visit prior to coverage of tele-mental health services will unnecessarily restrict access to behavioral health care. Removing the in-person requirement would improve equitable access to care for low-income patients and those in rural communities. We note that our position on in-person visit requirements is unique to tele-mental health services.

Additionally, to improve access to integrated tele-mental and behavioral health care in primary care settings, **the AAFP encourages Congress to establish a new program for adults that mirrors the Pediatric Mental Health Care Access Program (PMHCA) at the Health Resources and Services Administration (HRSA).** This program, which was most recently reauthorized in 2022, promotes behavioral health integration into pediatric primary care by using telehealth.

PMHCA has helped address increased mental and behavioral health needs in light of ongoing workforce shortages by meeting children and adolescents where they are. In Fiscal Year 2020, approximately 3,000 children and adolescents in 21 states were served by pediatric primary care providers who contacted the pediatric mental health team. Two out of every three of these patients lived in rural and underserved counties.[17]

Family physicians frequently share concerns and frustration that when they refer their patients for mental or behavioral health care, their patients are not always able to find a clinician in-network or one accepting new patients. As a result, family physicians see patients with exacerbated behavioral health symptoms and are sometimes forced to send them to the emergency department when there are no other acute care options. Given the well-documented shortage of mental and behavioral health clinicians and the growing demand for specialized care, a HRSA-funded program that provides primary care clinicians with virtual access to specialists could increase timely access to care for adult patients, particularly in rural areas.

Thank you for the opportunity to offer these recommendations. The AAFP looks forward to continuing to work with you to advance policies that improve access to health care for our nation's rural communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

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Board Chair, American Academy of Family Physician
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Founded in 1947, the AAFP represents 129,600 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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