AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

July 8, 2020

Admiral Brett P. Giroir, M.D.
Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Captain Paul Reed
Deputy Assistant Secretary for Health, Medicine and Science
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
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Dear Assistant Secretary Giroir and Deputy Assistant Secretary Reed:

On behalf of the American Academy of Family Physicians (AAFP), which represents 136,700 family physicians and medical students across the country, I write to provide feedback for the request for information regarding health system resilience.

What have been the most significant barriers to assessing, monitoring, and strengthening health system resilience in the U.S.?

The most significant barrier to health system resilience is the lack of a long-term, objective, and consistent support necessary for public health and primary care. Funding for primary prevention has consistently been under resourced, public health departments are understaffed, and there is a lack of investment in family medicine and primary care. Our current health care system is fragmented and prioritizes hospital-based care. Further, health access is not evenly distributed across the country. As a result, the U.S. spends more time and money treating health challenges than preventing them or managing them through early interventions.

Primary care spending lags in the United States compared to most other high-income countries. Across payers, including both public and private insurance, primary care spending in the United States amounts to approximately five to eight percent of all health spending, with an even lower percentage in Medicare, compared to approximately fourteen percent of all health spending in most high-income nations. Nations with greater investment in primary care reported better patient outcomes and lower health care costs. Significant variation in primary care investment exists within the states, according to a Robert Graham Center analysis, yet states with higher levels of primary care investment also report better patient outcomes.

What policies and programs can be improved to mitigate the risk of COVID–19 and avoid negative impacts on patient outcomes?

The most significant way to reduce the risks associated with COVID-19 would be to prevent or manage chronic health conditions, address the needs of vulnerable patients, provide

administrative flexibility for physicians to enable them to focus on patient care, and ensure continuous health care access.

Medicaid. Medicaid payment rates are, on average, two-thirds that of Medicare, but can be worse depending on the state. Research has suggested that low Medicaid payment rates have led to lower physician participation; limited access to physician care leads individuals to seek primary care at hospital emergency rooms. Increasing primary care payment rates in Medicaid to at least Medicare rates is critical to ensuring access to primary care, leading to better quality of care for patients and decreased costs for states. Providing emergency funding during disaster and pandemic emergencies is an essential for health system resilience. Especially during times of crisis, it is critical that family physicians can take on new patients and have the resources to appropriate care.

Countercyclical Federal Matching Assistance Percentage (FMAP). While Medicaid spending can adjust in response to fluctuations in economic activity, the current formula for sharing Medicaid expenditures between states and the federal government does not allow for a rapid increase in federal contributions when state economic conditions decline, nor does it provide a mechanism for additional federal contributions to stimulate growth during a national recession. Therefore, it is critical that the FMAP be altered and tied to economic indicators.

Special enrollment period (SEP). During pandemics, the federal government and state-based exchanges should open a special enrollment period to allow uninsured individuals to enroll in health coverage. Despite significant increases in the number of individuals with health insurance over the past decade, nearly 24 million non-elderly adults remain uninsured nationwide.

Telehealth flexibility. During pandemics, physicians must be able to quickly pivot between providing in-person and virtual care in order to maintain care continuity and protect patients, themselves, and their staff. Even as practices resume in-person care in the wake of COVID-19, physicians need adequate and stable telehealth reimbursement in order to maintain the capacity to provide virtual care to their patients.

What is your definition of health system resilience within the context of your organization? Does the definition of resilience need to be defined differently based on geographic region and/or the domain of healthcare being assessed?

Any definition of health system resilience must include the need for a robust family physician and primary care physician workforce. The AAFP recommends training models that produce enough primary care physicians to meet state population needs and to reduce current maldistribution challenges that significantly impacts rural communities. Recognizing family physicians' role in providing a range of health care services for women, the AAFP created the 25x2030 initiative to grow and retain the necessary number of family physicians .

The AAFP supports The Teaching Health Center Graduate Medical Education Program (THCGME) that trains primary care and other needed specialties in outpatient, community-based settings. The AAFP also supports National Health Service Corps program and proposals to attract more physicians into rural and medical-underserved areas.

Family physicians comprise just under 15 percent of the U.S. outpatient physician workforce, yet they perform 23 percent of the visits that Americans make to their physicians each year.[i] In rural areas, an even greater proportion, about 42 percent of these visits are to family physician offices. According to a 2019 Robert Graham Center brief, the aging population of family physicians will worsen current rural workforce shortages, particularly in 12 states (AL, AZ, CT,

FL, ME, MS, NH, NM, OK, TN, TX, and VT).[ii] This is an important consideration for resilience efforts because in the case of COVID-19, some physicians tested patients and provided hospital-based care despite their own personal risks for infection based age or health status. Additional data from the Robert Graham Center for Policy Studies in Family Medicine and Primary Care show that, in 2018, a little less than 22 million people — about 7% of the population — received care in a hospital, compared with the more than 190 million people — roughly 60% of the population — who received care from a family physician. Furthermore, in a given year, roughly 260,000 people are hospitalized for upper respiratory infections (URIs). By contrast, 19.5 million patients are seen by primary care physicians for the same condition, suggesting that most COVID-19 patients will ultimately be evaluated and cared for in the primary care setting.[iii]

While we appreciate the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* and subsequent efforts that HHS and the Centers for Medicare & Medicaid Services (CMS) have initiated in support of the health care system to respond to this pandemic, the reality is that much greater support is critically and urgently needed for primary care if we wish to maintain a viable health care system throughout the pandemic and into the future. Data suggest[iv] that the health and well-being of our citizens are in jeopardy if primary care is not put on a more sustainable path. Also, 35 percent or primary care practices are not ready for the next COVID-19.[v] The AAFP recommends that policymakers sustain primary care access by providing immediate and targeted funding of at least $20 billion from the Provider Relief Fund to primary care physicians in all practice settings. A weekly survey conducted by the Primary Care Collaborative indicates that 47 percent of primary care physicians have furloughed staff, and 45 percent reported being unsure whether they would have enough funding to remain in business.

The COVID-19 pandemic has underscored that fee-for-service is an inappropriate payment structure to meaningfully resource primary care. This public health emergency should accelerate shifts to more sustainable models of care such as prospective global payments for primary care which also represent a greater overall investment. Several models have shown promise by paying practices in a prospective manner to allow for investments and resources to treat their populations while balancing the need to deliver specialized care based on unique patient needs. This system also incorporates the best practices for patient care such as a focus on a patient-centered medical home, administrative flexibility, consistent funding, and a focus on patient health outcomes.

Again, the AAFP appreciates the opportunity to comment on this important issue. For more information, please contact Sonya Clay (sclay@aafp.org).

Sincerely,

John S. Cullen, MD, FAAFP
Board Chair

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[i] AAFP, Position Paper, Rural Practice, https://www.aafp.org/about/policies/all/rural-practice-paper.html
[ii] Robert Graham Center, 2019, accessed online: https://www.aafp.org/afp/2019/0615/p743.html
[iii] https://www.pbgh.org/news-and-publications/pbgh-covid-19-resources/584-online-hill-briefing-the-stakes-for-primary-care
[iv] Primary Care Collaborative Survey, July 1, 2010, accessed online: https://www.pcpcc.org/2020/07/01/more-one-third-primary-care-clinicians-not-ready-next-covid-19-surge
[v] PCPCC Survey, July 1, 2020