AMERICAN ACADEMY OF FAMILY PHYSICIANS

November 26, 2019

The Honorable Danny Davis
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Brad Wenstrup
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Terri Sewell
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Jodey Arrington
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

Dear Representatives Davis, Sewell, Wenstrup and Arrington:

On behalf of the American Academy of Family Physicians (AAFP) and the 134,600 family physicians and medical students we represent, I write in response to the Request for Information posted by the U.S. House of Representatives Committee on Ways and Means' Rural and Underserved Communities Health Task Force on November 15, 2019.

The AAFP appreciates the Task Force issuing this request for information since we agree rural communities face unique challenges related to the delivery and financing of health care which contribute to disparities in health outcomes. Seventeen percent of our members practice in rural communities which is the highest percentage of any medical specialty. Many rural family physicians 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.

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 and mounting administrative burdens 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. Some of 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.

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The AAFP offers the following feedback to certain questions posed by the Task Force to help develop legislation that promotes delivery of health care in rural communities that is sustainable, accessible, high-quality, value-based, and provided at the lowest cost possible.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional, systems or factors outside of the health care industry that influence health outcomes within these communities?

   Rural Americans tend to be older, poorer, sicker, and have fewer physicians to care for them than their urban and suburban counterparts. According to the Centers for Disease Control and Prevention, rates for the five leading causes of death (heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke) are all higher in rural communities.

   These worse health outcomes can be attributed, in part, to a lack of preventive and screening services, treatment of illnesses and timely urgent and emergency services. A recent poll by the Robert Wood Johnson Foundation found that roughly one-quarter of adults living in rural areas did not have access to health care within the past few years. The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas. The primary care workforce shortage disproportionately impacts rural America in part because graduate medical education training is not evenly distributed nationwide and because costly and burdensome administrative requirements are threatening the financial viability of solo and small physician practices.

   Rural communities also tend to have higher rates of poverty, and rural residents are more likely that their urban and suburban counterparts to be uninsured or underinsured. 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.

   In addition, it is important to consider distances to nearest hospitals, fewer 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.

2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

   The AAFP supports the implementation and expansion of multi-payer models for primary care founded on the five key functions of the medical home (comprehensive care, patient-centered care, coordinated care, accessible services, and quality and safety) that result in increased investment in primary care.

   A significant body of evidence clearly shows the medical home driving reductions in health care costs and/or unnecessary utilization, such as emergency department visits, inpatient hospitalizations and hospital readmissions. Those who participate in multi-payer programs with specific incentives or performance measures linked to quality, utilization, patient engagement or cost savings, such as the Centers for Medicare & Medicaid Services' Comprehensive Primary Care initiative (CPCi) have seen the most impressive results.

The AAFP has developed five principles to ensure that social determinants of health are appropriately accounted for in the design of alternative payment models.

Tele-ICU, Tele-Radiology and Tele-stroke programs can be a useful adjunct for rural physicians and have been shown to improve outcomes while allowing patients to stay in their local communities.

Project ECHO is another promising model that seeks to enhance access to mental health and substance-use disorder treatment via remote and telehealth training and practice support for primary care clinicians, particularly in rural and underserved areas.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

The Committee should consider the impact of low patient volumes on physician payment. As payment transitions from volume to value, physicians are being increasingly held accountable for quality and utilization performance. A physician's performance is more easily skewed by outliers when they have a lower patient volume. A single patient with a catastrophic health event can skew performance and result in an inaccurate assessment of physician. This, in turn, can negatively impact payment. Additionally, rural physician practices may lack the funding and workforce support to meet key clinical quality measures. The Committee should ensure value-based payment models make appropriate adjustments on quality and utilization assessment for rural practices. **Practices should not be assessed on measures unless the measure is both valid and reliable for low patient volumes, and payers should consider the high resource burden associated with quality reporting.**

Primary Care Health Profession Shortage Area (HPSA) scoring prioritizes population-to-provider ratio over travel time to the nearest source of care. This leaves rural communities at a disadvantage when there is not adequate funding of the National Health Service Corps (NHSC) to provide a family physician for areas with lower HPSA scores. Those areas need physicians, but the funding does not extend far enough to provide a NHSC clinician. **Increased funding for NHSC primary care physicians would allow more rural Health Professions Shortage Areas to qualify for family physician placements.**

The committee should consider the importance of having an adequate physician workforce in rural underserved areas to improve outcomes which is at least as important as the ratio of patients to physician. A functional system includes a capability to handle obstetrical, medical, and trauma related crises for all age groups. Well trained family physicians and provider teams can fulfill this role.

4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —
   a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?
   b. there is broader investment in primary care or public health?
   c. the cause is related to a lack of flexibility in health care delivery or payment?

A major impact of closing service lines and hospitals has been in the increase in maternal and infant mortality rates. The resulting obstetrical deserts cause travel delays for delivery and/or prenatal care and higher rates of preterm delivery, more mothers and babies are dying as a result of this trend as compared to 20 years ago.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) often serve as the "backstop" to hospitals in rural and other underserved communities. When those hospitals reduce or eliminate service lines, FQHCs and RHCs are often the first to feel the brunt as patients transition to them for those service lines. This transition can further strain the primary care safety net provided by such health centers and clinics. Absent a broader, greater investment in primary care, that strain may sink those health centers and clinics, adding to the gaps in service availability created by the hospital service line reduction or elimination.

Family physicians are typically the most common source of primary care in these communities, either in independent practice or via staffing of FQHCs and RHCs. Those family physicians may often be the ones staffing the hospital and its service lines (e.g. emergency department, maternity care), both as a service to the community and to maintain practice viability. When hospitals reduce or eliminate service lines staffed by family physicians, that may threaten the viability of those physicians' practices outside the hospital, which, again, can exacerbate the gaps in service available to the community. **A broader, greater investment in primary care could offset and prevent such consequences.**

The rising cost of liability insurance premiums contributes to the growing loss of obstetrical services in rural communities. Higher premiums threaten the viability of some rural hospitals and make it difficult for rural areas to recruit or retain an adequate number and mix of physicians. Through the Federal Tort Claims Act (FTCA), the federal government offers a way for certain rural health centers to lower their malpractice insurance costs. **FTCA expansion could help rural communities struggling to provide high-risk services due to the increasing cost of private medical malpractice insurance.**

Efforts are also needed to ensure primary care physicians can practice their full scope of care by removing barriers that lack an evidence base and are based solely on physician specialty. **The AAFP believes physician privileges should be evidence-based and recognize the documented training and/or experience, demonstrated abilities and current competence of the physician.**

6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The Teaching Health Center Graduate Medical Education (THCGME) is one of the most successful, efficiently run programs in the country. Since its inception, this program has trained over 880 primary care physicians and dentists, and evidence suggests that physicians who train in community-based underserved settings are more likely to practice in those settings. Data from the American Medical Association Physician Masterfile show that the majority of family medicine residents will stay within 100 miles of where they train.

Exposing medical students and residents to rural care settings may increase the likelihood that they ultimately choose to practice in rural communities. Some ways to do this include supporting rural preceptorships in medical school, rural rotations during residency and designated rural training tracks. **The Rural Residency Planning and Development Program supports the development of new rural residency programs or rural training tracks in family medicine, internal medicine and psychiatry.**

Physicians utilizing J-1 visa waivers play an important role in addressing the current physician shortage. **Conrad 30 has been a highly successful program, enabling underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training.**

The National Health Service Corps (NHSC) 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.

7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

   Family Physicians can provide behavioral and substance use disorder care as well as urgent and emergency oral care. Tele-psychiatry for behavioral health can be a useful adjunct when paired with a family physician and clinical social workers in rural settings. Family physicians currently provide substance use disorder care within rural communities and provide medication assisted treatment for substance use disorders. **Improving payment for these services is essential as this population is resource intensive.**

   In addition to primary care specialties, the **THCGME program trains residents in psychiatry and general dentistry.**

10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

    While 42% of visits that Americans make to their physicians each year are to family physicians, the traditional Medicare Graduate Medical Education (GME) does not provide an adequate number of family medicine residency positions to increase the number of medical school graduates making a career choice of family medicine. The AAFP's Graduate Medical Education Financing Policy discusses in detail six principles to improve the production of primary care physicians.

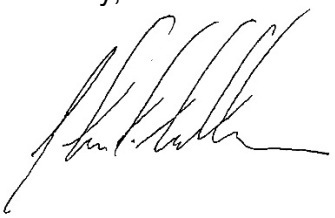
    U.S. investments in primary care lag behind most other high-income countries (5-8% of all health spending vs. approximately 14%). The lag is even worse in Medicare and Medicaid – two programs that are dominant in rural practices. Nations with greater investment in primary care reported better patient outcomes and lower health care costs. Thus, increasing investment in primary care (e.g. through piloting and testing new models of payment and care delivery as the Center for Medicare and Medicaid Innovation is doing) could strengthen patient safety and care quality in health systems that provide care to rural and underserved populations.

    While all health care professionals share an important role in providing care to patients and should be permitted to practice at the top of their license, those living in rural areas should not be relegated to a lower level of qualified care because of where they live. To promote health equity, it is critical to keep in mind that skillsets and expertise are not interchangeable with that of a fully trained physician.

In addition to the responses provided above, the AAFP encourages the Task Force to review a detailed annotated bibliography developed by the Robert Graham Center to inform policy discussions regarding the widening gap of health care 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.

We appreciate the opportunity to provide this feedback and look forward to working with the Task Force to advance bipartisan legislation that improves the health of rural and underserved communities. For more information, please contact Erica Cischke at 202-232-9033 or ecischke@aafp.org.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair