



June 23, 2021

Shalanda Young
Acting Director
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Re: Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government

Dear Acting Director Young:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 133,500 family physicians and medical students across the country, I write in response to the [request for information](#) regarding Methods and Leading Practices for Advancing Equity and Support for Underserved Communities through Government as published in the *Federal Register* on May 5, 2021.

The AAFP [commends](#) the administration's commitment to advance racial equity and stands ready to partner with the Office of Management and Budget (OMB) and other agencies to address barriers to achieving equity. As the largest medical society devoted solely to primary care, 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. The AAFP has also developed [tools](#) for our members to use in their practice.

We 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. To this end, we have developed a comprehensive list of [policy recommendations](#) for addressing social determinants of health and mitigating health disparities. We support policies and programs that:

- promote [universal access](#) to essential health services
- increase access to affordable healthy food
- lift people out of poverty
- offer rapid access to permanent affordable housing

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- protect individuals against discrimination
- improve equitable access to high-quality education and equitable educational achievement
- improvements to the built environment, particularly for disadvantaged communities
- offer home visitation in pregnancy and early childhood
- ensure social determinants of health are accounted for in alternative payment models
- integrate education on social determinants of health and their impacts on health inequity into all levels of medical education

Investing in primary care is an essential strategy to achieving health equity: evidence confirms primary care mitigates health disparities and improves patients' access to and utilization of low-cost, high-value care that ultimately results in better patient outcomes and population health.^{1,2,3,4} The AAFP recommends the administration employ a Health in All Policies approach to policymaking, invest in equitable, affordable access to comprehensive primary care, and [integrate](#) primary care with public health. Below we provide additional detail on strategies, programs, and policies to achieve these goals.

Equity Assessments and Strategies

Improve Existing Methodologies for Determining Budget Neutrality and Federal Savings

Existing methodologies for calculating costs and savings associated with health programs and policies may undermine health equity. For example, the long-term positive impacts of access to comprehensive primary care and adherence to recommended preventive health services are often not accounted for when determining the cost of a program or the estimated savings to the federal government. Similarly, models do not account for savings across government programs, particularly when they are administered by other federal agencies. These limitations undermine the passage of federal legislation or expansion of successful programs meant to mitigate the systematic and root causes of health inequities due to the projected cost.

Since the Center for Medicare & Medicaid Innovation (CMMI) is required to demonstrate cost savings or budget neutrality when piloting alternative payment models (APM), issues with the existing methodologies have also inhibited the creation and advancement of APMs that could address pervasive health disparities. To truly ameliorate this, OMB may consider developing a new methodology or equipping agencies' Office of the Actuary with tools to calculate the long-term cost and savings more comprehensively across government funding streams.

Constructing Alternative Payment Models to Advance Health Equity

As advocates for facilitating our transition to value-based care, the AAFP is mindful that health care innovation could exacerbate health disparities if APMs are not intentionally designed to advance health equity. The AAFP's position paper on quality measurement in primary care states that measures used in value-based payment must be properly risk-adjusted to account for factors such as demographics, comorbidities, patient behavior and preference, competing patient priorities, and social determinants of health to level the playing field and avoid financially penalizing entities or health care professionals for factors outside their control. Measures can be risk-stratified and/or populations can be segmented so complex patients can be included in measures and the data can be analyzed by subpopulations. Exceptions and exclusions can be added to measure specifications to

account for patient behavior, values, and choices and to avoid penalizing clinicians for delivering care according to patient-centered goals.

Performance measures can identify gaps in services and outcomes at the entity, community, and population levels, and they can be used to direct allocation of public and private resources to address unmet needs. Such measures should not lead to financial penalties for low performance. Rather, they should lead to investment of resources to improve equity, access, and socioeconomic factors that impact health and health care. Measurement should not have the effect of diverting resources away from the most important factors influencing health and health care, such as social determinants of health, *or from the organizations that serve the most vulnerable*. However, we are concerned existing measure specifications and risk adjustment methodologies do not adequately adjust for social factors and may negatively impact physician practices caring for those patients who are most impacted by pervasive inequities.

Social determinants of health greatly impact health outcomes, however to date, most payers have not adjusted payment rates based on social risk factors. As the healthcare landscape continues to shift to a value-based environment, the ability for physicians to provide comprehensive care, inclusive of social-needs, has become increasingly important. Payment adjustments based on social risk factors increases resources and creates opportunities for practices to identify patients who would benefit from those resources.⁵

One potential mechanism for adjusting payments is to use indices of social risk, such as the Robert Graham Center's (RGC) [Social Deprivation Index](#) (SDI), which provides a single index of social deprivation at many different geographic levels, such as census tract, block track, and/or zip code. The RGC SDI is a composite measure of area level deprivation based on seven demographic characteristics collected in the American Community Survey and used to quantify the socio-economic variation in health outcomes. The use of such indices to adjust value-based payments better aligns health care resources with population needs in a reliable and evidence-based manner.

Swiftly Develop Regulations to Prohibit the Sale and Manufacturing of Menthol Cigarettes and Flavored Cigars

The AAFP [applauds](#) the Food and Drug Administration's (FDA's) recent announcement that it will promulgate regulations to prohibit the sale and manufacturing of menthol cigarettes and flavored cigars. Despite a promising decrease in general cigarette smoking, menthol cigarette smoking has decreased at a much slower rate and even increased slightly in recent years.⁶ Menthol cigarettes are more addictive and harder to quit than unflavored tobacco and have been aggressively marketed to Black communities and young people.⁷ In fact, as a result of decades of predatory advertisement from big tobacco companies, non-Hispanic Black adults account for the largest percentage of menthol cigarette smokers and 7 out of 10 Black young people who smoke use menthol cigarettes, compared to about half of all young people.⁸ **The AAFP encourages the FDA to act swiftly to begin the rulemaking process and implement this ban on the sale and manufacturing of menthol cigarettes and flavored cigars.** The AAFP also appreciates the FDA's ongoing reiteration that this ban does not penalize tobacco consumers. The administration could also provide guidance to states or work with the Department of Justice to ensure individuals are not unjustly penalized or targeted by law enforcement once this ban is in effect.

Enhance Health Care Data Collection and Standardization

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, including public and private payers. Unaligned data collection processes among payers contribute to physicians' administrative burden and interfere with interoperability. 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.

Artificial Intelligence and Machine Learning in Health Care

The AAFP believes artificial intelligence and machine learning (AI/ML) have great promise to transform the practice of medicine and improve outcomes for patients, which is why we created the AAFP Innovation Laboratory in 2019 to drive innovation using advanced technological platforms and tools, including AI/ML. The AAFP also partnered with the CMMI to launch the Artificial Intelligence Health Outcomes Challenge.

While the AAFP strongly supports efforts to harness AI/ML technology, we recognize the limitations and pitfalls of this technology. It is critically important that AI-based solutions do not exacerbate racial and other inequities pervasive in our health care system. We strongly believe systematic approaches must be implemented to evaluate the development and implementation of AI/ML solutions into health care. For example, we can look to the FDA Safety and Innovation Act (FDASIA) efforts to create a risk-based oversight framework to guide the development of a systematic approach. This will help balance innovation and patient safety as new AI/ML solutions are deployed in health care.

Recent studies indicate clinical guidance and existing algorithms for clinical decision making may be based on biased studies and exacerbate inequities.⁹ One study found an algorithm used in hospitals systematically discriminated against Black patients.¹⁰ Experts also predict that rapid implementation of AI-solutions amid the COVID-19 pandemic may widen the already disparate impact of the virus.¹¹ To improve trust in AI/ML solutions, these issues will need to be addressed head-on before AI-solutions can be successfully integrated into clinical care. It will also need to be made clear that AI-

based technology is meant to augment decisions made by the user, not replace their clinical judgement or shared decision making.

Regulations governing health data privacy, payment, coverage, and liability will need to be modified to support the use of AI/ML solutions. Access to large volumes of high-quality data is needed to enable safe and effective AI solutions. AI/ML technology must be trained on large datasets that are representative of the population they are meant to serve. Absent a representative dataset, AI/ML solutions can develop bias and ultimately exacerbate inequities. However, the existing data privacy regulatory framework is not optimized to balance access to and use of large data sets with individual privacy.

AI solutions provide a new type of offering that has characteristics of both a diagnostic test and a consultation. Our current payment, coverage, and liability frameworks are not designed to accommodate this new hybrid offering. Federal policies facilitating the use and affordability of AI/ML technology are needed to improve access and ensure these new technologies do not exacerbate existing inequities.

Barrier and Burden Reduction

Exception to cost allocation requirements in OMB Circular A-87 for health and human services programs

We recommend the Department of Health and Human Services (HHS) re-issue a previous exception to the cost allocation requirements set forth in the OMB Circular A-87 to allow Federally-funded health and human services programs to benefit from investments in the design and development of State eligibility-determination systems for State-operated Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP).^{12,13} In 2011, HHS and the U.S. Department of Agriculture issued this exception to encourage states to leverage the technology investments and advances in streamlined enrollment required under the Affordable Care Act (ACA) for modernizing eligibility and enrollment for other safety-net benefits. Reviving this time-limited tool would be an important step enabling the creation of data connections between public agencies that make major contributions to enrolling the eligible uninsured and preventing coverage losses among people who are currently enrolled.

The Kaiser Family Foundation recently estimated that nearly two-thirds of the country's uninsured now qualify for Medicaid, CHIP, or federal financial assistance to purchase private insurance, including more than 40 percent who are offered zero-cost insurance but are not enrolled.¹⁴ Providing an exception to the cost allocation requirements in OMB Circular A-87 would allow states to do more to integrate the eligibility determination and enrollment functions across health and human services programs, realizing efficiencies for States and serving individuals and families. Integrated eligibility systems would allow individuals and families to access critical safety-net services without having to complete multiple enrollment processes and without government workers processing the same information again and again.

States could also use this waiver to connect health programs to external sources of data that can verify eligibility without requiring individuals and families to complete repetitive paperwork. States could also simultaneously enroll eligible individuals into health coverage as well as other programs for

which they are eligible by improving data matching, establishing more robust referral mechanisms, streamlining business processes, and notifying program participants of their potential eligibility for other benefits. For example, in 2019, Supplemental Nutrition Assistance Program (SNAP) served 44 percent of Medicaid-enrolled children and 41 percent of Medicaid enrolled non-elderly adults.¹⁵ SNAP receipt establishes more than a 90 percent likelihood of continuing eligibility for Medicaid.¹⁶ Thus, data matching showing that a Medicaid beneficiary receives SNAP can help indicate likelihood of continued eligibility. Additionally, the U.S. Postal Service's address database, which is updated weekly to incorporate changes of address, is useful for states in determining eligibility and renewals.¹⁷ By promoting more integration of IT systems across health and social services programs through the A-87 exception, HHS can encourage states to reimagine how to deliver government services for the 21st century.

HHS can also use the A-87 exception to encourage states to integrate all safety-net programs, regardless of state agency. Given the millions of Americans who faced unemployment during the COVID-19 public health emergency and the technology challenges state unemployment agencies faced to meet the unprecedented demand, states will be looking to improve their unemployment IT systems. This presents an opportunity for HHS to partner with U.S. Department of Labor to leverage federal technology investments that will be made to improve access to unemployment to also improve access to health and social services. For example, creating more direct linkages between unemployment insurance benefits and Medicaid, CHIP, and ACA-exchange plans could help consumers who may have lost employer-based coverage avoid a gap in coverage and disruption in treatment.

Improving Equitable Access to Broadband and Digital Devices

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 relied on broadband and existing 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.¹⁸ Without broadband, many individuals living in Tribal, rural, and urban areas are unable to connect with their physicians via telehealth to receive needed care. Given that access to telehealth services can help remove other barriers to care, such as transportation or childcare, improving broadband access could help advance health equity. Broadband is also needed to address other social needs, such as education, safe housing, and employment, or 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 using other technologies. For example, Medicare regulations should enable patients to receive telehealth services from their primary care physician via audio-only modalities. In addition to covering audio-only services, Medicare policies should ensure appropriate payment for audio-only telehealth visits that fairly reflects the work performed by physicians.

Federal and state COVID-19 vaccination efforts have also demonstrated how programs must account for disparate broadband access.¹⁹ Older Americans, those without broadband, and those without computers or smartphones were disadvantaged when looking for appointments for COVID-19

vaccines. These barriers to access resulted in lower immunization rates among minoritized and low-income communities that persist today. Future vaccination efforts should include opportunities for patients to sign-up for appointments that do not require fast internet speeds or navigating multiple websites several times a day.

These lessons can also be incorporated into permanent public programs. Pew Research Center found lower income individuals are much less likely to own a computer or tablet and therefore are much more dependent on smartphones than higher income individuals.²⁰ This emphasizes the importance of ensuring applications for public programs can be accessed and filled out on a smartphone, not just a traditional computer. In fact, Pew confirms lower income individuals were much more likely to have completed a job application using a smartphone.²¹ Federal programs should be designed to ensure equitable access, regardless of the device used to apply. Since state assistance programs are also vital for many low-income individuals, the administration could also provide states with guidance for how to effectively transition applications for state programs so they are available on a smartphone.

Language accessibility

Numerous qualitative studies have found that patient language barriers result in poor coordination of health care, limited connection and engagement between patient and physician, and less patient involvement in their care.²² Improving language accessibility is necessary for inclusive care, especially for preventive services and chronic or complex disease management. Section 1557 of the ACA prohibits discrimination in healthcare on the basis of race, national origin, sex (including sexual orientation and gender identity), age, and disability. Previous administrations rolled back these protections, including protections for patients with limited English proficiency. The AAFP [expressed](#) serious concerns over this change and [applauded](#) the current administration for reinstating protections for LGBTQ+ patients. **Section 1557 protections must be fully restored for patients with disabilities and limited English proficiency.** The AAFP is committed to ensuring patients and physicians and other clinicians have the resources they need for collaborative and effective healthcare coproduction. To ensure primary care physicians do not continue to face undue financial burden on their practices, **it is essential that Medicare and other federal health programs provide appropriate funding and payment for language and interpreter services in health care settings.**

Financial Assistance

Reduce the Burden of Billing Medicaid and Support Medicaid Payment Parity for Primary Care Services

The American Rescue Plan Act took several steps to meaningfully expand Medicaid eligibility and coverage for low-income Americans. However, low Medicaid payment rates and significant administrative burdens associated with billing Medicaid continue to create barriers to accessing care for beneficiaries and exacerbate care inequities. **To ensure all Medicaid beneficiaries can access high-quality care when they need it, federal action is needed to mitigate these burdens and improve Medicaid payment rates.**

Medicaid covers some of the most vulnerable populations, including low-income children, pregnant women, and families, children with special health care needs, non-elderly adults with disabilities, and older adults. As a result of this coverage and access to essential health services, Medicaid beneficiaries are less likely than those who are uninsured to postpone or forgo needed care due to cost, and less likely to have suffered a decline in their health in the past six months.^{23,24} Medicaid coverage for low-income pregnant women and children has helped lower maternal, infant, and child mortality in the U.S.^{25,26} Children enrolled in Medicaid are more likely than their uninsured peers to get medical check-ups, attend more days at school, graduate and enter the workforce.²⁷

In 2019, Medicaid payments remained significantly lower than Medicare and private insurance rates, as in prior years, despite growth in Medicaid enrollment since 2008.²⁸ On average, Medicaid pays 66 percent of the Medicare rate, with some states paying as low as 33 percent.²⁹ These inadequate rates jeopardize access to care and the financial stability of physician practices. These concerns have become even more acute: 91 percent of primary care practices recently reported staffing shortages, 48 percent reported severe practice stress and burnout, and ongoing financial distress is leading to practice mergers and closures.^{30,31,32}

Low Medicaid rates have historically been a barrier to health care access for Medicaid enrollees. Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.³³ Managed care plans report caps on clinician's Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.³⁴ Patients covered by Medicaid experience longer office wait times, and both low-income patients and their physicians report that low payment rates lead to shorter, inadequate visit times.^{35,36} On the other hand, evidence indicates patient access improved when Congress raised Medicaid primary care payment rates to Medicare levels in 2013-2014.

One study found that appointment availability increased during the "primary care fee bump" and decreased after it expired.³⁷ States with larger payment increases also had greater improvements in appointment availability and child health outcomes.^{38,39} Other studies found the fee bump did not significantly increase physicians' participation in the Medicaid program, likely due to the temporary nature of the payment increase.⁴⁰ The Medicaid and CHIP Payment and Access Commission surveyed physicians about the primary care fee bump and found that it modestly increased willingness to accept new Medicaid patients, though physicians reported early operational issues delaying the start of increased payments were a major challenge.^{41,42} Taken together, the available evidence indicates that, coupled with more rigorous oversight, enacting Medicaid payment parity for primary care for a longer period of time could meaningfully improve access for Medicaid enrollees.

In fact, several states chose to maintain some level of primary care Medicaid payment increase after 2014.⁴³ A 2018 analysis of Medicaid managed care organizations also found many plans use payment enhancements to recruit and retain primary care physicians into their network, suggesting improved payment is an effective strategy for increasing physician participation and ensuring access.⁴⁴

Coupled with low payment rates, physicians experience significant administrative barriers when trying to receive Medicaid payments. These administrative issues come at a cost. A new study estimates physicians lose 16 percent of Medicaid payments to billing problems, compared with 7 percent for Medicare and 4 percent for commercial payers.⁴⁵ Since physician practices lose a significant portion

of their already much lower Medicaid payments to billing issues, the researchers found many practices respond by refusing to accept Medicaid patients in states with worse billing hurdles.⁴⁶

Primary care physicians form lasting relationships with their patients in order to provide comprehensive, continuous, coordinated primary and preventive care. While a temporary fee increase may help support physician practices operating on thin margins, a longer term or permanent solution would provide the necessary assurance that they will be paid adequately moving forward. The administrative burdens physicians experience when billing Medicaid must also be addressed to ensure equitable access to care.

Improving access to care for Medicaid beneficiaries can mitigate health disparities. Medicaid plays a particularly vital role in providing coverage to pregnant women, rural residents, individuals with disabilities, as well as Black, Native American and Indigenous, Hispanic, and people of color. More than 30 percent of Black, Indigenous, and Hispanic adults and children have Medicaid coverage.⁴⁷ By improving coverage and affordability of primary care, the ACA significantly reduced racial and ethnic disparities in care utilization and access.⁴⁸ However, the odds of residing in a physician shortage area are much higher for predominantly Black neighborhoods.^{49,50} Sixty-one percent of Primary Care Medical Health Professional Shortage Areas are also in rural areas, suggesting these populations may be impacted most by changes in Medicaid physician participation.⁵¹ Increasing Medicaid rates would help to further mitigate health inequities.

Access to primary care physicians will be even more critical for patients who contracted COVID-19, which has disproportionately impacted Black, Hispanic, and Native American and Indigenous people.⁵² Early studies suggest about 30 percent of people who were previously infected with COVID-19 experience persistent debilitating symptoms.⁵³ Ensuring timely access to primary care physicians for these patients, who are also more likely to receive coverage through Medicaid, is essential for mitigating the pervasive inequities that were exacerbated by the pandemic.

Protecting and improving access to primary care services is essential to our ability to end and recover from the COVID-19 pandemic, as well as our nation's preparedness for future crises. Medicaid enrollment has increased by 6 million since the start of the pandemic and enrollment is expected to continue to increase as a result of pandemic-related job loss.⁵⁴ The 6.2 percent Federal Medical Assistance Percentage increase has largely helped to avoid physician payment reductions. However, primary care practices were operating on thin or even negative margins before the pandemic and are still working to make up revenue losses. The anticipated increase in Medicaid enrollment will pose challenges for physicians who will have to choose between the financial viability of their practice and their ability to provide care to the growing number of Medicaid beneficiaries. Should states cut payment rates to physicians, the negative impact on patients and physician practices would be even more dire.

Data indicate that Medicaid payment was worse in states with higher Medicaid enrollment even before the pandemic.⁵⁵ Given increased enrollment during the pandemic, as well as new incentives for states to permanently expand Medicaid eligibility, states may face additional budgetary pressure to constrain Medicaid spending. Absent federal action, states may reduce payment rates to address rising costs caused by increasing Medicaid enrollment.

Given the significant growth in Medicaid eligibility and enrollment over the last year, federal action is needed to improve and secure long-term access to primary care for Medicaid beneficiaries. Federal financial support and oversight would help ensure primary care physicians can accept new Medicaid beneficiaries and spend as much time with the patient as they need without sacrificing the financial stability of their practice.

The AAFP further recommends that HHS provide guidance to state Medicaid programs and managed care plans to minimize billing disruptions. The Department could also conduct a study to determine whether billing disruptions are worse when billing Medicaid managed care plans.

Restore Medicaid Managed Care Oversight

The lack of federal enforcement and oversight of Medicaid managed care plans, as well as recent regulatory changes to weaken network adequacy requirements, may negatively impact Medicaid beneficiaries' access to care. CMS should enforce the Medicaid Access Rule, which requires states to issue Access Monitoring Review Plans (AMRP) to report Medicaid beneficiaries' access to primary and other types of care every three years. Since states have not been required to submit AMRPs since 2016, they have also not been required to measure changes in access to care. Enforcing this rule would provide states and CMS with a regular mechanism with which to measure changes in access to care that may occur due to increased Medicaid eligibility and enrollment, such as during the COVID-19 pandemic.

CMS should also reverse recently finalized regulations weakening network adequacy requirements for managed care plans. The Medicaid and Children's Health Insurance Program Managed Care rule, finalized in November of 2020, rescinds requirements for states to set time and distance standards and instead requires that states set a "quantitative minimum" access standard for certain types of clinicians.⁵⁶ While time and distance standards are not perfect for ensuring patients' needs are met, the AAFP supported the inclusion of an objective federal network adequacy standard that acted as a floor for states in reporting data and monitoring access. Narrow networks threaten to disrupt continuity of care and existing patient-physician relationships, as well as limit timely access to primary care physicians.⁵⁷ As such, CMS should reinstate a minimum federal standard for network adequacy, which plans must meet and states may choose to build upon. Coupled with improved

Leveraging Graduate Medical Education (GME) to Diversify the Physician Workforce and Improve Equitable Access to Primary Care

Currently, Black, Hispanic, Native American and Indigenous, female, and rural populations are underrepresented in the physician workforce.⁵⁸ Additionally, most physicians come from an upper-middle class standing prior to entering undergraduate or medical school.⁵⁹ This means patients of racial and ethnic minority groups are less likely to find a physician who looks like them or comes from a similar cultural background, and many practicing physicians have limited experiences similar to those of low socioeconomic status.

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.⁶⁰ Studies show underrepresented minority physicians are more likely to practice in underserved and low income areas.⁶¹ 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.⁶² 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.^{63, 64}

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.

The AAFP [calls for](#) greater accountability for federal GME payments to correct the historical maldistribution of federal GME financing. Because the type and location of GME training is predictive of eventual practice location, ensuring new positions are allocated to health professional shortage and medically underserved areas will begin to address the lack of physicians in these communities. Studies show patient satisfaction and health outcomes are improved when physicians and their patients have concordance in their racial, ethnic, and language backgrounds.^{65, 66} Further, students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers, and more likely to choose primary care careers.⁶⁷ The current U.S. physician workforce includes roughly three times fewer physicians from Hispanic and Latinx backgrounds, and roughly two times fewer physicians from Black and African American backgrounds, compared to the general population.⁶⁸

In December 2020, as part of the Consolidated Appropriations Act of 2021, Congress allocated 1,000 new GME residency slots. CMS subsequently published the Fiscal Year 2022 Inpatient Prospective Payment System proposed rule, which included CMS' proposed methodology for allocating the 1,000 GME slots. The AAFP [urged](#) CMS to apportion the new residency slots in a way that would effectively alleviate ongoing physician shortages in rural and underserved areas and therefore improve equitable access to comprehensive care across the nation. We supported the agency's proposal to prioritize applications from hospitals located in geographic Health Professional Shortage Areas (HPSAs) and that care for underserved populations. **However, the Academy recommends CMS also prioritize applications from hospitals that produce a high proportion of trainees who ultimately practice in HPSAs.** This would offer a more comprehensive and sustainable approach to addressing disparate access to care and health inequities by investing in physicians who will care for underserved communities well into the future.

To increase training opportunities in community settings and improve access to primary care for underserved populations, the administration should support permanent authorization and expansion of the Teaching Health Center Graduate Medical Education (THCGME) program. The THCGME program is vital to encouraging residency training in community settings, like Federally Qualified Health Centers, that are more likely to serve Black, Indigenous, Asian, and Hispanic populations.⁶⁹ It is one of the most successful and efficiently run programs in the country, and has a proven track record of achieving its legislative mandate to train the next generation of primary care physicians. To date, the THCGME program has trained more than 1,148 primary care physicians and dentists, 65 percent of whom are family physicians.⁷⁰ Additionally, most family physicians practice within 100 miles of residency programs, therefore helping remedy the uneven distribution of

physicians in rural and underserved areas. The primary care physician shortage can be significantly reduced by increasing residency slots in current programs and expanding the THCGME program to all 50 states.

The AAFP [recommends](#) the National Health Service Corps (NHSC) remove the existing funding cap for individuals and reinstate the goal of zero disparities in health care due to race, class, income, geography, language, or immigration status. The AAFP's position paper on [Keeping Physicians in Rural Health Practice](#) indicates the NHSC is essential to recruiting physicians who will continue practicing in rural areas long term. The NHSC offers scholarships or loan repayment as incentives for physicians to enter primary care settings that treat Americans in rural and underserved areas. By addressing medical school debt burdens, the NHSC also helps ensure wider access to medical education opportunities. This is a critical financial incentive for medical students, and program participation should reflect the need for underrepresented physicians in the workforce.

Thank you for the opportunity to provide comments on the RFI. The AAFP looks forward to working with the administration to meaningfully advance health equity. Should you have any questions, please contact Meredith Yinger, Senior Regulatory Strategist, at myinger@aafp.org or 202-235-5126.

Sincerely,



Gary LeRoy, MD, FAFAP
Board Chair
American Academy of Family Physicians

¹ Hostetter, J., Schwarz, N., Klug, M. *et al.* Primary care visits increase utilization of evidence-based preventative health measures. *BMC Fam Pract* 21, 151 (2020). <https://doi.org/10.1186/s12875-020-01216-8>.

² National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25983>.

³ Ferrante JM, Lee JH, McCarthy EP, *et al.* Primary care utilization and colorectal cancer incidence and mortality among Medicare beneficiaries: A population-based, case-control study. *Annals of Internal Medicine*. 2013;159(7):437–446. Available at: <https://pubmed.ncbi.nlm.nih.gov/24081284/>

⁴ Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. *JAMA Intern Med*. 2019;179(4):506–514. doi:10.1001/jamainternmed.2018.7624

⁵ Phillips R *et al.* Adjusting Medicare Payments for Social Risk To Better Support Social Needs. *Health Affairs Blog*, June 1, 2021. DOI: 10.1377/hblog20210526.933567 <https://www.healthaffairs.org/doi/10.1377/hblog20210526.933567/full/>

⁶ Menthol and Cigarettes | Smoking & Tobacco Use | CDC. Published November 20, 2020. Accessed June 16, 2021. https://www.cdc.gov/tobacco/basic_information/tobacco_industry/menthol-cigarettes/index.html

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