



July 8, 2020

The Honorable Lamar Alexander
Chair
Senate Health, Education, Labor, and
Pensions Committee
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member
Senate Health, Education, Labor, and
Pensions Committee
Washington, D.C. 20510

Dear Chairperson Alexander and Ranking Member Murray:

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 share recommendations in response to the white paper titled “Preparing for the Next Pandemic.” We appreciate the opportunity to provide comments for what can be enacted by the end of this year.

Since the March 13 public health emergency declaration in response to the spread of the novel coronavirus (COVID-19), medical and public health professionals have responded to the needs of individuals, the public, and their governments. Some volunteered to put themselves in harm’s way. Medical professionals in all specialties have been on the front lines and stand ready to help support the planning necessary to prepare for a potential next pandemic. According to the U.S. Centers for Disease Control and Prevention (CDC), there have been more than 2.6 million COVID-19 infections and more than 128,000 deaths. Understanding the potential for devastation, preparedness planning with widespread input is sensible right now.

Improve Primary Care Coordination

Primary care physicians, especially family physicians, play an important role in emergency response, recovery, and resilience efforts. Although the practice settings and patient populations may vary, caring for the general patient population is essential during emergencies and pandemics. Primary care physicians triage patients for testing, provide medication management assistance, support those with chronic conditions, support medical surge efforts, and address individuals’ acute care needs. The general population relies on primary care physicians for most care, information, and counseling. Therefore, establishing a primary care–centered strategy would benefit preparedness efforts.

Statistics 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.¹ As we prepare for the next pandemic, the AAFP urges the follow strategies.

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- **National preparedness efforts must include a clearly defined primary care strategy.** We understand that plans are under development to distribute a potential COVID-19 vaccine, under the U.S. Department of Health and Human Services' (HHS) Assistant Secretary for Preparedness and Response (ASPR). As those efforts continue, officials must design guidance for primary care physicians, regardless of the practice setting. Officials should also prioritize the distribution of drugs, supplies, and equipment for primary care physicians. This should include allocation of resources to enhance telehealth capabilities.
- **Coordination with primary care organizations.** According to the HHS ASPR Technical Resource, Assistance Center, and Information Exchange (TRACIE), there is an interest in enhanced emergency response planning. The AAFP recommends that HHS enhance its primary care coordination efforts with investments in medical surge information dissemination among national organizations and state chapters. During the COVID-19 response efforts, the AAFP [called](#) for enhanced coordination, information, and targeted resources. Based on feedback from members, planning efforts should consider practice-based physicians in rural communities and medically underserved areas where significant gaps in communication and resources occurred during this pandemic.

Personal Protective Equipment and Medical Supplies

According to a March Primary Care Collaborative [survey](#), 43% of respondents reported having no capacity to test patients for COVID-19; 39% were able to test only a narrow subset of patients. Accessing personal protective equipment and high-quality masks was also a challenge. A Primary Care Collaborative April [survey](#) indicated that 58% had used homemade masks in their practices. Addressing the medical community's supply needs will be especially important as the country considers how to respond to the needs of high-risk patients, specifically those with chronic diseases who are vulnerable to infectious diseases.

- **Primary care liaison.** The AAFP urges the creation of a primary care liaison within CDC, ASPR and the Federal Emergency Management Agency to engage physicians who work in primary care outpatient settings.
- **Prioritize primary care professionals for immunizations and supplies.** The nation's family physicians, pediatricians, and internal medicine specialist should be given priority access to immunizations and supplies. Also, agencies must consider that the pandemic's impact among these physicians may create challenges for small and solo practices operating on small margins and struggling to procure immunization supplies.

Maintain the Viability of Primary Care

The World Health Organization [indicates](#) that primary care can play a significant role in pandemic response by differentiating patients who have infections from those who present with symptoms. They also engage in early detection, supporting the social and emotional needs of vulnerable patients, and reduce the demand for hospital services. Maintaining a strong primary care system is therefore essential.

The COVID-19 pandemic has underscored that fee-for-service is an inappropriate structure to meaningfully resource primary care. This public health emergency should accelerate shifts to more sustainable payment models such as prospective global payments for primary care. Several models have shown promise by resourcing 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.

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 more support is needed for primary care if we wish to maintain a viable health care system throughout the pandemic and into the future. Data [suggest](#)ⁱⁱ 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 of primary care practices are not ready for the next COVID-19.ⁱⁱⁱ

Primary care practice viability ensures that our nation's physicians can meet the health needs of their patients, manage chronic diseases, and support vaccine administration. Primary care practice closures will result in an exacerbation of complications due to chronic conditions, resulting in worse outcomes and higher costs. The following are some AAFP recommendations.

- **Sustain primary care access.** The AAFP recommends that policymakers [sustain](#) primary care access by providing targeted relief funds to primary care physicians in all practice settings. A weekly [survey](#) conducted by the Primary Care Collaborative indicates that 47% of primary care professionals have furloughed staff, and 45% reported being unsure whether they would have enough funding to remain in business. It is essential that Congress and/or HHS immediately designate at least \$20 billion from the Provider Relief Fund for this distinct purpose.
- **Reinstate the Medicare Accelerated and Advance Payment Program.** The AAFP supports legislation (H.R. 6837/S. 3750) to reinstate the Medicare Accelerated and Advance Payment Program for Part B suppliers and improve the loan terms to ensure it is available to primary care physicians in need. The AAFP has also [called on](#) Congress to fix a tax penalty in the *CARES Act* by clarifying that Provider Relief Funds and similar funding provided in response to COVID-19 are not taxable, and that entities receiving these funds maintain tax deductions attributable to these funds.

Prioritize Health Care Access and Chronic Disease Management

Data show that primary care is associated with improved patient care outcomes, even when controlling for socioeconomic factors. A [study](#) cited by the CDC indicates that 90% of severe COVID-19 hospitalized patients have a chronic health condition. These risks apply to racial and ethnic minorities and those living in rural communities. Recent data also indicate that patients are forgoing vaccinations and preventive care visits. Physicians also indicate that COVID-19 has led to an increased number of patients [experiencing](#) psychological or mental health challenges. Therefore, the AAFP urges the following steps.

- **Support Medicaid parity.** Increasing Medicaid payment rates to no less than the comparable Medicare payment rates is an important priority. This proposal was approved as the *Health Care Education and Reconciliation Act (HCERA)*, part of the *Patient Protection and Affordable Care Act*. The *HCERA* included a two-year increase in Medicaid primary care payment rates but unfortunately was not reauthorized. Therefore, Medicaid payment rates continue to lag those of Medicare; nationwide, 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 rates in Medicaid is critical to ensuring access to primary care, leading to better quality of care for patients and decreased costs for states. The *Ensuring*

Access to Primary Care for Women and Children Act of 2020 ([S. 4088](#)), introduced on June 25, would raise Medicaid rates for primary care services to Medicare levels for two years and during and immediately following future public health emergencies to ensure that those in need have access to care. Especially during times of crisis, it is critical that physicians can take on new patients and have the resources to appropriately care for them. To date, 40 million individuals have filed for unemployment, and as people lose access to job-based health coverage Medicaid will play a vital role in ensuring access to COVID-19 testing and treatment. We urge Congress to include Medicaid [parity](#) with Medicare in this in any pandemic response proposal.

- **Establish a Countercyclical Federal Matching Assistance Percentage (FMAP).** Medicaid is a countercyclical program: Enrollment and spending increase when a downturn in the economic cycle leads to rising unemployment and growth in both the low-income population and the number of people losing employer-sponsored insurance. However, the current financing structure has limited effectiveness as an automatic economic stabilizer. 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. The AAFP endorses the *Coronavirus Medicaid Response Act*, which would connect the FMAP to state unemployment levels, so federal aid increases in accordance with state economic downturns. Under current law, states must rely on Congress to obtain an FMAP increase. This bill removes that requirement and allows decisions to be made solely on the economic needs of a state.
- **Special enrollment period (SEP).** During pandemics, the federal government and state-based exchanges should open a special enrollment period. Despite significant increases in the number of individuals with health insurance over the past decade, nearly 24 million non-elderly adults remain uninsured nationwide. Many of the uninsured do not qualify for employer-based insurance coverage, may not know where to access care if they become sick, and are more likely to forgo seeking care entirely, due to affordability concerns. Unfortunately, unless a beneficiary is undergoing a “qualifying life event” such as pregnancy or marriage, new enrollment in these health plans is limited. To allow uninsured individuals the ability to enroll in a health insurance plan during a critical period such as a pandemic, it is necessary that the federal government establish an SEP immediately. Additionally, to make sure individuals are aware of all SEPs, consumer-facing insurance “navigators” should be trained to conduct robust outreach and provide virtual and telephonic enrollment support to attract and enroll newly eligible people in qualified health plans. Establishing an SEP would ensure that many who are currently uninsured have the opportunity to obtain coverage and receive access to care during a pandemic. Patients’ well-being is a priority; access to health insurance not only facilitates access to care but also allows them the peace of mind associated with being covered.
- **Reduce cost barriers for patients with high-deductible health plans.** Management of chronic conditions will be important as we prepare for the fall’s influenza season and for future pandemics. Even if a person has insurance, the fear of incurring medical debt can discourage patients from engaging in health-seeking behaviors. The AAFP supports the *Chronic Disease Management Act* ([H.R. 3709/S. 1948](#)), which will allow high-deductible health plans (HDHPs) to provide patients access to certain chronic care services and treatments with no cost-sharing before meeting their deductible. Research shows that the increased use of HDHPs is associated with delays in care, testing, and treatment that can lead to avoidable disease progression. Another important priority is passage of the *Primary Care Patient Protection Act* ([H.R. 2774/S. 2793](#)). This [legislation](#) would ensure that patients

enrolled in HDHPs have access to primary care services. Research shows that cost barriers to care are disproportionately harmful to low-income individuals and those with chronic conditions.

- **Eliminate cost sharing within the Medicare chronic care management program.** The AAFP has consistently supported [proposals](#) to eliminate the patient cost sharing associated with chronic care management (CCM) codes under the Medicare program. We are pleased the House Ways and Means Committee approved the *Health Opportunities to Promote Equity Act* (H.R. 3346) in 2019. We are also pleased that CMS proposed [increasing](#) the payment and reducing administrative burdens under the Medicare Physician Fee Schedule for complex care that physicians provide through evaluation and management services.

Preserve Telehealth Access

Many physicians have quickly deployed new technologies or updated existing capabilities to deliver telehealth services. Given these investments, an automatic return to pre-COVID telehealth policies would be a terrible and huge setback for physicians as well as for patients' access to care. In the event of a future pandemic, 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 payment to maintain the capacity to provide virtual care to their patients. The AAFP recommends the following:

- **Maintain telehealth flexibility.** The AAFP has [called on Congress](#) to enact legislation to eliminate geographic and originating site restrictions for Medicare telehealth services to ensure all beneficiaries nationwide can continue to access virtual care, regardless of their location, when the public health emergency ends.
- **Support the doctor-patient relationship.** As Congress and the administration contemplate other long-term changes to telehealth policy, it is critical to recognize that telehealth is one modality of providing care but cannot and should not fully replace in-person primary care. Telehealth is most effective within the context of an existing patient-physician relationship, and the AAFP has [called on Congress](#) to design policies regarding coverage, payment, and tax treatment of telehealth services to strengthen that relationship rather than disrupt it.

Enhance the Primary Care Workforce

The pandemic has demonstrated the urgency of building and financing a robust, well-trained, and accessible primary care system in our country. The AAFP recommends training models that produce enough primary care physicians to meet state population needs and to reduce current maldistribution challenges that significantly affect rural communities. The Teaching Health Center Graduate Medical Education Program (THCGME) addresses that by training primary care and other needed specialties in outpatient, community-based settings. The THCGME program has a strong track record of attracting and retaining physicians to medically underserved areas (MUA) since its creation in 2010.

Family physicians compose just under 15% of the U.S. outpatient physician workforce, yet they perform 23% of the visits that Americans make to their physicians each year.ⁱ In rural areas, an even greater proportion, about 42%, 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 (Alabama, Arizona, Connecticut, Florida, Maine, Mississippi, New Hampshire, New Mexico, Oklahoma, Tennessee, Texas, and Vermont).ⁱⁱ

Millions of people are depending on our health care system, and it is time for Congress to make the necessary investments to ensure that the health care system is prepared to provide care to people in this time of national emergency.

- **Reauthorize and fund the Community Health Center program.** Community Health Centers (CHCs) provide primary care to more than 29 million people in communities large and small, regardless of individuals' ability to pay. Health centers often are the only sources of care for people in rural and urban underserved communities. Recognizing the importance of CHCs, Congress provided supplemental funding within the CARES Act. Reauthorizing the program will help ensure stability and is crucial for long-term pandemic planning.
- **Reauthorize and fund the THCGME program.** Investment in the THCGME program is critical to ensuring that our nation has a robust primary care workforce in the future. Continued underinvestment in primary care education and training will only result in further strains on our primary care system and weakens our ability to confront and manage future outbreaks and pandemics. More important, funding the THCGME program will ensure that hundreds of family physicians are available to provide care to vulnerable populations today. Residents training in THC programs provide care to more than 1 million patients per year, and programs operate primarily within Federally Qualified Health Centers. Now is the time to boldly invest in the primary care infrastructure by investing in this important program with increased and permanent annual funding.
- **Enact Liability and Good Samaritan laws.** The AAFP supports shielding physicians and facilities from lawsuits arising from the provision of health care services during a declared public health emergency. Congress should provide targeted and limited liability protections where health care services are provided or withheld in situations that may be beyond the control of physicians/facilities (e.g., following government guidelines, directives, lack of resources) due to the emergency. The protections should extend only to those who provide care in good faith during the public health emergency (plus a reasonable time, such as 60 days, after the emergency declaration ends), not in situations of gross negligence or willful misconduct. In addition, Congress should grant immunity from civil actions for alleged negligence to any licensed physician who in good faith renders emergency care without compensation, through the nationwide expansion of Good Samaritan laws.
- **Expand Conrad 30.** The Conrad 30 visa waiver program has been highly successful in enabling underserved communities to recruit both primary care and specialty physicians after they complete their medical residency training. Physicians utilizing the program play an important role in addressing the shortage of primary care physicians across the country and in reducing health care disparities in rural and underserved communities. The AAFP supports allowing the program to expand beyond 30 slots, allowing "dual intent" for J-1 visa physicians seeking graduate medical education; and establishing new employment protections and a streamlined pathway to a green card for participants. Expanding and reauthorizing the program will create a pool of physicians already in place and able to quickly respond to a public health emergency.

Reduce Health Care Disparities

Members of racial and ethnic minorities have been disproportionately affected by COVID-19. They are likely to live in densely populated settings or in communities that are farther away from economic resources and medical facilities. They also are likely to live in multi-generational housing and serve as family caregivers. Compared with other groups, minority groups are overrepresented in vocations where they often encounter the public, and often lack paid sick leave. These factors make it challenging for them to follow social-distancing guidelines and result in higher COVID-19 rates. The challenges that arise through social determinants, including exposure to discrimination, undermine

individuals' sense of well-being, raise the body's stress hormone levels, and weaken immune systems. These personal and sociological factors heighten minorities' risks for chronic diseases, which are associated with severe COVID-19 hospitalizations.

On April 9, the AAFP joined other health organizations in sending a [letter](#) calling for increased data collection regarding the race and ethnicity of those infected with COVID-19. We are pleased with the recent HHS [announcement](#) that labs will be required to report racial, ethnic, and geographic data. It is our hope that these and other efforts will help us better understand how to allocate resources and improve health equity.

- **Health disparities taskforce.** The AAFP supported the *COVID-19 Racial and Ethnic Disparities Task Force Act* (H.R. 6763/S. 3721). If approved, the legislation would develop a task force and disseminate findings that may help guide federal activities, based on research into why disparities exist.
- **Support social determinants of health (SDoH) policies.** The AAFP supports the *Social Determinants Accelerator Act of 2019* (H.R. 4404/S. 2986), which would provide funding and technical assistance to states and localities to develop SDoH strategies for high-need Medicaid patients. The legislation also encourages federal agency coordination. The data [show](#) that extending health coverage to more low-income people is an important way to reduce health disparities between people of color and others in the United States. Medical societies, public health experts, hospitals, and payers increasingly recognize that SDoH strategies can also improve patient and population health.
- **Incorporate service workers into planning efforts.** The AAFP recommends that pandemic planning consider the needs for service employees, who are at heightened risk because of their vocations. These individuals are likely to be at risk and to working in public-facing jobs.

Improve Vaccines and Serology Testing Access and Awareness

Physicians will need to respond to patients seeking advice and counseling to administer new antibody testing, treatments, and vaccines to address a novel viral epidemic. Further flattening the curve may also depend on health care systems' ability to measure the extent of the disease and its impact on society. To that end, professional societies will need to provide resources to rapidly disseminate information about new testing, treatments, and the eventual vaccine. Primary care physicians are among the most trusted individuals able to effectively educate patients on vaccines and testing. The National Vaccine Action Plan consistently indicates that the medical home is the ideal setting for encouraging vaccinations, particularly for those with comorbid conditions. Physicians and medical societies have called for evidence-based vaccine counseling resources. The COVID-19 pandemic will require counseling for more patients, which heightens the need for this information.

- **Support evidence-based testing and vaccine counseling.** The AAFP recommends that the CDC and other relevant agencies develop evidence-based information that will help support patient-doctor decision making associated with serology tests and COVID-19 vaccines. The AAFP also supports policies to encourage HHS to share best practices for increasing antibody testing and immunizations. The AAFP supports the creation of grants to national societies to develop and deploy updated data to medical professionals. Funding could support multi-pronged education and training programs that would support online modules, CME development, and patient materials.
- **Immunization information systems improvements.** The AAFP supports funding for state immunization information systems (IIS) data modernization, upgrades, and modifications. These resources are necessary for interoperability and bidirectional data exchange between IIS and community immunization providers to reduce the administrative burdens primary care

physicians, pharmacists, and other health care providers face in many parts of the country. Such modernization efforts are essential to ensure that immunizers can capture every administered dose of COVID-19 vaccine and accurately match doses to individual patients and report vaccine distribution and uptake by geographic area and special population, such as first responders or those with chronic health conditions.

- **Report barriers that influence adult vaccine rates.** A 2015 [study](#) published in the *Annals of Internal Medicine* indicates that primary care physicians observe numerous barriers when administering vaccines within the adult population. Those include insurance coverage, patient hesitance, stocking limitations, and point-of-care workflow challenges. There is limited research on the barriers that influence adult vaccines at both the patient and the point-of-care levels. The AAFP signed a joint [letter](#) recommending a Government Accountability Office study on vaccine administration barriers and potential solutions. We believe this is an area that deserves robust review. The government may also organize an interagency, multidisciplinary task force to develop detailed solutions that build on the National Vaccine Advisory Committee's general plan.
- **Improve public education efforts.** The AAFP [has urged](#) Congress to provide the CDC with sufficient funds to support state, local, territorial, and tribal partners and to conduct national or targeted education campaigns on the dangers of vaccine-preventable diseases and the value of vaccines.

Conclusion

Thank you for the opportunity to provide comments. We look forward to working with you on these recommendations in the months ahead. For more information, please contact Sonya Clay, Government Relations Representative, at sclay@aafp.org.

Sincerely,



John S. Cullen, MD, FAAFP
Board Chair

ⁱ <https://www.pbgh.org/news-and-publications/pbgh-covid-19-resources/584-online-hill-briefing-the-stakes-for-primary-care>

ⁱⁱ Primary Care Collaborative Survey (PCPCC), July 1, 2020, accessed online: <https://www.pcpcc.org/2020/07/01/more-one-third-primary-care-clinicians-not-ready-next-covid-19-surge>

ⁱⁱⁱ PCPCC Survey, July 1, 2020