AMERICAN ACADEMY OF FAMILY PHYSICIANS

September 28, 2023

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Smith:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 129,600 family physicians and medical students across the country, I write in response your request for information from the health care community on solutions and proposals to address chronic disparities in access to health care in rural and underserved communities.

Rural Americans often face greater socioeconomic barriers, such as higher poverty rates and lack of reliable transportation, than their average urban counterparts. They tend to be older and sicker, have a higher incidence of poor health outcomes, and are more likely to engage in risky behaviors such as substance use and smoking. Individuals in rural areas are also more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke as well as COVID-19.[i],[ii]

They also face significant barriers and challenges to accessing high-quality, comprehensive health care. Rural residents are more likely to be uninsured and are more likely to report difficulty obtaining needed health care than their urban counterparts, largely due to the limited number of clinicians and facilities in their area.[iii],[iv] Rural hospitals have closed at an alarming rate over the last ten years, and many rural populations face long travel times for primary and emergency care. Additionally, while many patients benefited from new telehealth flexibilities due to the COVID-19 public health emergency (PHE), rural individuals were less likely to have broadband access and therefore less likely to connect via video for virtual visits.[v]

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

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Sustainable Provider and Facility Financing

Primary care is the only health care component where an increased supply is associated with better population health and more equitable outcomes, leading the National Academies of Sciences, Engineering, and Medicine (NASEM) to call it a common good.[vi] Evidence clearly demonstrates that improving access to longitudinal, coordinated primary care reduces costs, improves utilization of recommended preventive care, and reduces hospitalizations. Yet the United States has continuously underinvested in primary care, which only accounts for a mere five to seven percent of total health care spending in the country.[vii,viii] The consequences of this underinvestment are particularly pronounced in rural communities, which represent nearly two-thirds of primary care health professional shortage areas (HPSAs) in the country.[ix]

Rural primary care doesn't just happen in office-based setting or a hospital. It happens at all hours, in all settings across the community: in a patient's home, in the grocery store parking lot, and at high school football practices. However, our current regulatory and policy environment and misaligned incentives are severely threatening the long-term viability of rural family medicine, particularly for independent practices, and instead rewarding consolidation that does not always meaningfully invest in comprehensive, high-quality primary care.

In particular, the piecemeal approach existing fee-for-service payment systems and the Medicare Physician Fee Schedule (MPFS) take to finance primary care undermines and undervalues the whole-person approach integral to primary care and hinders the ability for rural family physicians to provide care in a way that is organic and responsive to their community**. Investing away from FFS and in the transition to value-based care will allow rural primary care to be delivered in the ways that's most meaningful for the community's needs.**

While fee-for-service is not the future of primary care, though, it is the present. **Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future** – one that rewards quality of care over volume of services. Independently practicing physicians need an environment that allows them to thrive, but inadequate payment rates threaten their long-term viability. This is especially true in rural and medically underserved communities, where simply participating in Medicare and Medicaid is economically detrimental to independent practices. However, backing out would mean that these patients – who make up the greatest portion of a panel – are unlikely to access care elsewhere.

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling health care consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. Rural areas see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Because of the less-profitable patient population, studies have indicated that market concentration is higher in low-income areas.[x] For small, rural practices and hospitals, the effects of consolidation may be different. Mergers and acquisition can play an important role in preserving existing sites of care (and oftentimes, the only site) with insufficient margins. However, it also often results in the closure of service lines not deemed highly profitable – including primary care – and may worsen equitable access to care in these communities.[xi]

One family physician in the Midwest shared his experience of trying to keep the doors open for his rural community practice. For more than 20 years, he provided care in the community he called home. He spent 50 percent of his time working in the emergency department at the local hospital

simply to try and keep his primary care practice financially afloat. Unfortunately, it wasn't enough. In 2020, he closed his practice not due to COVID, but due to the financial instability, and left primary care entirely to seek refuge in the emergency department.

The Academy strongly urges the Committee to consider legislative solutions, including reforms to MACRA, and support positive policy proposals that would address unsustainable FFS payment rates for physicians and promote community-based primary care, including in rural and underserved communities, rather than incentivizing consolidation.

This is why the AAFP, alongside 36 other organizations representing clinicians, patient advocates, and other health care stakeholders, have expressed our strong support for a proposal by the Centers for Medicare and Medicaid Services (CMS) to implement an add-on billing code known as G2211 in the CY24 MPFS. G2211 would be billed with codes for office/outpatient evaluation and management (E/M) visits to better recognize the inherent resource costs clinicians incur when longitudinally managing a patient's overall health or treating a patient's single, serious or complex chronic condition. In simpler terms, G2211 reflects the time, intensity, and practice expenses needed to meaningfully establish relationships with patients and address most of their health care needs with consistency and continuity.

Sustained continuity of care has been shown to improve quality and reduce health care spending, including for patients with chronic conditions such as diabetes, by decreasing hospitalizations and emergency department use and improving uptake of preventive services.[xii] This add-on code is a much-needed investment in strengthening patient-clinician relationships by supporting clinicians' ability to foster longitudinal relationships, address unmet social needs, and coordinate patient care across the team. Evidence indicates increasing payments for these types of services reduce patient appointment wait times and supports the provision of services that improve patient health and can reduce costs.[xiii,xiv,xv] **The Academy strongly urges Congress to support CMS' proposal to implement G2211.** Allowing this code to go into effect would be an incremental but meaningful step toward bolstering access to all the services that Medicare beneficiaries need and appropriately paying for the complex care that primary care physicians provide each and every day, with the likelihood to yield long-term health care savings.

The Academy has heard from some family physicians that their practices having to stop accepting new Medicare beneficiaries altogether due to financial constraints, leaving them unable to address the needs of the entire community that they're trained to serve. However, some of these same physicians have also indicated that positive policy proposals such as G2211 would be a turning of the tide that allows them to revisit these practice decisions and begin accepting new Medicare beneficiaries again. G2211 is an opportunity to correct decades of underinvestment in comprehensive primary care that has undeniably contributed to the chronic access and outcome disparities seen across rural and underserved communities.

Unfortunately, **statutory budget neutrality requirements undermine positive policy changes**, such as implementation of G2211, by requiring Medicare to offset increased investment in one area of medicine with cuts to others. This inevitably pits primary care and other specialties against each other instead of enabling Medicare to pay appropriately for all types of care. This dynamic has only exacerbated our underinvestment in primary care within the fee-for-service payment system: primary care's voice is drowned out as organized medicine competes for arbitrarily limited resources without adequate focus on the services that would drive population health improvements and health equity.

Both MedPAC and the Board of Trustees have also recently raised concerns about rising costs for physician practices and impacts on patient care, with each body recommending Congress provide

payment updates for physicians. Specifically, the Board of Trustees warned that, without a sufficient update or change to the payment system, they "expect access to Medicare-participating physicians to become a significant issue in the long term."[xvi]

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

Since the passage of MACRA, it has become clear that stable, adequate fee-for-service payments are also a vital component to the value-based care transition, particularly for practices serving rural, low-income, and other underserved communities. Physician practices that struggle to keep their doors open cannot possibly transition into alternative payment models or hire care managers and behavioral health professionals. Practice transformation and quality improvement require significant investment in practice capabilities including technology, people, and new workflows.

Statutory budget-neutrality requirements and the lack of annual payment updates to account for inflation will, without intervention from Congress, continue to hurt physician practices, slow the adoption of value-based payment models, accelerate consolidation, and jeopardize patients' access to care, especially in rural and underserved communities. In October 2022, the Academy submitted robust recommendations to Congress on reforming MACRA to address challenges affecting our members and their patients. The AAFP urges Congress to expeditiously consider additional reforms to MACRA and Medicare physician payment, such as relief from budget neutrality requirements, to modernize Medicare fee-for-service payments.

Geographic Payment Differences

In addition to already being insufficient, Medicare payments to physicians are generally less in rural areas than in suburban and urban areas, as reflected in the geographic adjustment factors associated with the Medicare Physician Fee Schedule (MPFS). This current structure of low payment can prevent physicians from being able to feasibly accept as many patients as urban and American Academy of Family Physicians 3 suburban physicians, further disadvantaging individuals living in rural areas and consequently reducing their access to primary care services. For this reason, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas).

MACRA requires CMS to apply payment adjustments to Medicare Part B fee-for-service payments based on an eligible clinician's (EC) performance in the Merit-based Incentive Payment System (MIPS). ECs with a MIPS final score above the performance threshold receive a positive adjustment while those below the threshold receive a negative adjustment. The adjustments must be budget neutral – meaning the positive adjustments are equal to the negative adjustments. As such, both the positive and negative adjustments are made on a sliding scale with the exception that those in the bottom quartile automatically receive the maximum negative adjustment for the year.

The AAFP shares CMS' interest in fostering continuous performance improvements that lead to better outcomes for patients. However, we are concerned that the current design of MIPS which focuses on individual clinician performance using largely process rather than outcomes measures is not driving care improvements as much as it is adding administrative complexities that detract from patient care and unfairly penalizing small and rural practices. While most physicians have met or exceeded the

MIPS performance threshold, physicians in small and rural practices consistently have lower than average MIPS scores. As the performance threshold increases, it will become more difficult for small and rural practices to avoid a negative adjustment.

In CY2024, CMS is proposing to increase the MIPS performance threshold. The estimated impact of the increased threshold is significant – nearly half of all ECs would receive a negative payment adjustment based on the proposed increase. **Even more alarming, CMS estimates that nearly 65% of ECs in solo practices, 60% of ECs in small practices, and 62% of ECs in practices with 16-99 clinicians will receive a negative payment adjustment**, confirming that the MIPS program is using negative payment adjustments from the majority of clinicians in small practices to fund positive adjustments for clinicians working in large health systems. These estimates demonstrate that the MIPS program is not driving continuous quality improvement and is instead on a path that will accelerate the closing and consolidation of small physician practices.

Based on these concerns and the recognition that the overarching goal of the Quality Payment Program (QPP) is to drive toward well-designed value-based payment, **the AAFP believes a broader overhaul of the entire program must be considered.** In our aforementioned comments on the MACRA RFI, the Academy outlined several recommendations to Congress on how to modify the MIPS program to make it a less burdensome, more meaningful on-ramp to APM participation for primary care physicians.

Aligning Sites of Service

It is imperative that Congress address misaligned incentives that reward consolidation and undermine independent practices. Currently, hospitals are directly rewarded financially for acquiring physician practices, freestanding ambulatory surgical centers, and other lower cost care settings and moving services into the hospital or hospital outpatient department setting. Medicare allows hospitals to charge a facility fee for providing outpatient services that can be safely performed in the ambulatory setting. Thus, the hospital increases its revenue by acquiring physician practices and beneficiaries are forced to pay higher coinsurance.[xvii]

The AAFP has long supported the advancement of thoughtful site neutral payment policies that would establish payment parity across care settings with careful consideration as to not unintentionally accelerate consolidation. We have called for an expansion of payment parity to all on-campus and off-campus hospital-based departments, as well as other facilities. We support reducing payment differences between sites of service since it enables patients to make more informed healthcare decisions by making costs more transparent and would reduce patient cost-sharing. As such, site neutral payment encourages patient choice based on quality rather than cost. It is the AAFP's policy that patients should have reasonable freedom to select their physicians, other providers, and healthcare settings.

The AAFP greatly appreciates your continued leadership on this issue as a sponsor of the recently introduced Lower Costs, More Transparency Act (H.R. 5378), which ensures that payment for physician drug administration services will be the same in an off-campus hospital outpatient department (HOPD) as in a physician's office. We have urged Congress to swiftly pass this measure, while also continuing to advocate for additional action to build upon and advance more substantial site neutral payment policies.

Health Care Workforce

Two of the strongest predictors that a physician will choose rural practice are specialty and background: Family physicians are more likely than those with less general training to go into rural practice, and physicians with rural backgrounds are more likely to locate in rural areas than those with urban backgrounds.[xviii] Other factors associated with increased likelihood that a physician will choose rural practice include the following: training at a medical school with a mission to train rural physicians; osteopathic training; training that includes rural components; and participation in the National Health Service Corps.

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

The Teaching Health Center Graduate Medical Education (THCGME) Program plays a vital role in training the next generation of primary care physicians and addressing the shortage and maldistribution of physicians. To date, the program has trained more than 1,730 primary care physicians and dentists in community-based settings, 63% of whom are family physicians. THCGME graduates are also more likely to continue practicing primary care medicine and serving in medically underserved communities than those in Medicare GME–supported programs.

The AAFP has called for passage of the Doctors of Community (DOC) Act (H.R. 2569), which would permanently extend and expand the THCGME program. This bill is currently before the Energy & Commerce Subcommittee on Health. We are also deeply appreciative to you and your counterparts at Energy and Commerce and Education and the Workforce for the cross-committee work that has been done thus far this Congress to support THCGME by including a seven-year reauthorization – the longest in the program's history – and historic funding levels in the recently introduced Lower Costs, More Transparency Act (H.R. 5378). The program's authorization is set to expire on September 30, 2023, and we are urging swift Congressional action to pass this legislation to ensure greatly needed stability and ensure that funding for this critical program does not lapse.

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

While the new Medicare GME residency slots approved in the previous Congress were very much appreciated, additional action is needed to address disparate access to care in rural and other American Academy of Family Physicians medically underserved areas. Merely expanding the existing Medicare GME system will not fix the shortage and maldistribution of physicians. **Any expansion of Medicare GME slots should be targeted specifically toward hospitals and programs in areas and specialties of need**, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

One barrier to creating a more equitable and effective Medicare GME program is the lack of transparency in how funds are used. Medicare as the largest single payer – spends about $16 billion annually on GME – but it does not assess how those funds are ultimately used or whether they

actually address physician shortages.[xx] CMS has indicated their authority is limited to making payment to hospitals for the costs of running approved GME residency programs. Congress should pass legislation granting the Secretary of HHS and the CMS Administrator the authority to collect, analyze data on how Medicare GME positions are aligned with national workforce needs, and publish an annual report.

Innovative Models and Technology

Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. As discussed in the Academy's comments on the CY24 MPFS proposed rule and our Joint Principles for Telehealth Policy, **the AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship.** Telehealth should also enable higher-quality, more personalized care by making care more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the central value offered by a usual source of primary care, a continuous and comprehensive patient-physician relationship, increase fragmentation of care, and lead to the patient receiving suboptimal care.

The AAFP strongly believes telehealth is most appropriate when provided by a patient's usual source of care. We have significant concerns about the rapid proliferation of direct-to-consumer (DTC) telehealth vendors and the resulting interference with the established patient-physician relationship. In the last several years we've seen new and different types of DTC telehealth vendors emerge, including many for-profit start-ups that market themselves in ways that lead a consumer to believe they are providing true, person-centered health care. The dangers of these types of companies extends beyond disrupting the established patient-physician relationship but can range from misusing patient data to making patients vulnerable to medical misinformation and can even lead to patient harm.567 The AAFP remains concerned about the lack of regulation and transparency DTC telehealth companies are subject to and how that might impact patient care and outcomes. DTC telehealth cannot replace in-person care and is not an adequate replacement for a longitudinal patient-physician relationship, especially for patients with complex medical conditions.

Telehealth can be a lifeline for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, as noted previously, existing barriers continue to hinder the ability for individuals in rural communities to access quality telehealth services, as well. The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[xxi,xxii,xxiii]

In many instances, family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits. One recent study of FQHCs found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[xxiv] Therefore, permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs.

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work

required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Congress should implement policies that strengthen patients' relationships with their primary care physician, and physicians should not be paid less for providing patient-centered care. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

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

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

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

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

As the current payment landscape still largely relies on fee-for-service, it is vital to promote telehealth policies that provide adequate payment to protect access and the patient-physician relationship. **However, the best long-term solution is a payment system that moves away from the transactional and focuses on payment that better supports whole-person primary care.** Reliable, prospective payment that decouples payment from a specific care modality or encounter fosters innovations that allow practices to meet the diverse needs of their patient populations. Practices that are not hampered by stringent payment structures and documentation requirements

will be better prepared to meet future challenges associated with emergencies and disaster scenarios.

Thank you for the opportunity to share the family physician perspective and offer these policy recommendations on ways to better address the health care needs of rural and underserved communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Sterling N. Ransone, Jr., MD, FAAFP
Board Chair, American Academy of Family Physicians

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