AMERICAN ACADEMY OF FAMILY PHYSICIANS

Statement of the American Academy of Family Physicians

By

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To

U.S. Senate Committee on Finance

On

Rural Health Care: Supporting Lives and Improving Communities

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Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank you both for your bipartisan leadership to address issues impacting family physicians and their patients through this hearing entitled "Rural Health Care: Supporting Lives and Improving Communities."

The AAFP strongly agrees with Chairman Wyden's assessment in his opening statement that the United States must boost up primary care, which is "the backbone and front line of American health care and often experiences the greatest shortage of" clinicians. Senator Lankford also acknowledged in his opening statement that rural health care is not just delivered in hospitals, but in a variety of settings – including independent family physician practices, which he explicitly mentioned.

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 communities.

Appropriately Paying for Primary Care in Medicare and Medicaid

Payment for primary care is undeniably a workforce issue. The amount of money that we invest into primary care is a determining factor in whether or not we have a sufficient workforce in place to meet the needs of our population. However, despite spending more on health care than any of our peer nations, only a fraction of those dollars are spent on primary care and prevention. Specifically, only five to seven percent of our total national health care spending is on primary care.[vi] 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.[vii]

Lower compensation dissuades prospective physicians from pursuing primary care specialties and is one of the key drivers of financial instability for family medicine practices across the country. As a result, more independent primary care practices are acquiescing to consolidation – either selling to health systems, plans, or corporate entities for what is effectively pennies or closing their doors entirely – while too few new physicians are entering the field to take their place. Between 2021 and 2022, family medicine and internal medicine physicians accounted for more than 16,000 of the 71,309 doctors who left the workforce between 2021 and 2022.[viii]

In particular, the piecemeal approach fee-for-service (FFS) payment takes to financing primary care undervalues the whole-person approach integral to primary care and hinders the ability of family physicians to provide care in a way that is organic and responsive to our community. Primary care services are relatively undervalued in the Medicare Physician Fee Schedule, which leads to further devaluation across virtually all other payers who peg their payment rates to Medicare's or use Medicare's relative values to set their rates.

The retrospective, volume-based nature of FFS also fails to account for the costs of longitudinally managing patients' overall health. It does not provide practices with the time and flexibility to invest in the care management staff and population health tools that enable practices to efficiently and effectively meet patients' individual evolving health needs.

Rural communities are disproportionately impacted by insufficient FFS payments and the other pressure points fueling consolidation. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. They 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.[ix] For some 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 access to care in these communities.[x]

For these reasons, **the AAFP has long advocated to accelerate the transition to value-based care using alternative payment models (APMs) that provide prospective, population-based payments to support the provision of comprehensive, longitudinal primary care.** We strongly believe well-designed APMs provide primary care a path out of the under-valued and overly burdensome FFS payment system that exists today, and in turn will better enable the Medicare program to meet the needs of its growing and aging beneficiary population in new and innovative ways. Unfortunately, a dearth of primary care APMs and the inadequacy of FFS payment rates that often underlie APMs are undermining the transition to value-based care. Because most APMs are designed based on FFS payment rates, modernizing FFS payment for primary care is one essential strategy to support physicians' transition into value-based care.

Physician practices that struggle to keep their doors open cannot possibly transition into APMs 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. Therefore**, the Academy continues to urge the Committee to advance legislative solutions, including reforms to the Medicare Access and CHIP Reauthorization Act (MACRA), that would address unsustainable FFS payment rates for physicians and alleviate some of the associated administrative burden for practices, while promoting**

patients' access to continuous, comprehensive primary care. This includes providing an annual inflationary update for physician payment tied to the Medicare Economic Index and greatly needed reforms to existing budget neutrality requirements, which pit physician specialties against one another in a fight for scarce resources and hinder CMS' ability to appropriately pay for all the services a beneficiary needs.

Furthermore, Medicaid payment rates have a direct impact on patient access to primary care. Medicaid payment is on average 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent in some states.[xi] These low rates have historically been a barrier to physicians accepting more Medicaid patients. Reports from the Medicaid and CHIP Payment and Access Commission (MACPAC) show that physician acceptance of new Medicaid patients worsens as the ratio of Medicaid payment rates to Medicare allowances decreases.[xii] Physicians cite low payment as the primary reason they were unable to accept additional Medicaid patients.[xiii] Managed care plans report caps on clinicians' Medicaid patient panels and low physician participation in Medicaid are top challenges in ensuring access to care.[xiv] Medicaid enrollees experience longer office wait times, more difficulty scheduling visits, and both low-income patients and their physicians report low payment rates lead to shorter, inadequate visit times.[xv,xvi,xvii]

Meanwhile, 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.[xviii] 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.[xix] Raising Medicaid payment for primary care services can improve access to care for Medicaid beneficiaries and in turn mitigate health disparities.

Therefore, **the Academy continues to urge Congress to pass legislation that applies a Medicare payment rate floor to Medicaid primary care services** as a necessary step toward addressing the unsustainably low payment rates that are exacerbating existing health disparities and undermining patient access to essential care. However, the AAFP also continues to emphasize that Medicare payment rates have failed to keep up with inflation and should not be considered adequate. While Medicare is not a perfect comparator, we believe that it is a useful starting place because states continue to pay even lower Medicaid rates and Medicare rates are publicly available on a national basis.

Maternal Health and Obstetric Unit Closures

The United States has one of the highest maternal mortality rates in the developed world. Recent studies have shown that U.S. maternal mortality rates have stagnated or even worsened over time, while rates around the globe continue to fall.[xx] According to the World Health Organization, maternal mortality globally declined nearly 38 percent between 2000 and 2017.[xxi] During roughly the same period, maternal mortality in the United States increased by over 26 percent. In the U.S., approximately 700 women a year die as a result of pregnancy or related complications, yet the vast majority (84 percent) are preventable.[xxii] Significant disparities exist when these rates are broken down across demographic groups, with higher rates of mortality occurring among Black women, low-income women, and those living in rural areas.[xxiii]

The factors driving these disparities are complex and multi-faceted. They include but are not limited to access to and affordability of care, the intersection of demographic factors, and structural and systemic bias and discrimination. For example, the closure of rural hospitals and

obstetrics programs has led to enormous gaps in access to prenatal and perinatal services for pregnant people living in rural communities. In addition to the loss of facilities, there are compounding factors such as lack of transportation, increased poverty, increased rate of chronic diseases, and difficulty recruiting and retaining physicians to live and work in rural communities.

Between 2011 and early 2023, 217 hospital obstetric units closed, creating many maternity care deserts across the nation.[xxiv] As of 2018, over half of all rural counties lack a hospital providing obstetric services. Closures have been particularly focused in rural communities that are sparsely populated, have mostly Black residents, and were considered low income.[xxv] Family physicians were found to deliver babies more commonly in rural areas than in urban as many lack a dedicated obstetrician-gynecologist (OB/GYN).

The AAFP believes family physicians can play a significant part in addressing the disparities in maternal morbidity and mortality because they are trained to provide comprehensive care across the life course, including prenatal, perinatal, and postpartum care for people in the communities where they live. More than one in ten family physicians (13 percent) reported they delivered babies in 2022. A 2019 study found that in rural counties overall, there were about equal numbers of family physicians and OB/GYNs, but in urban counties there was about one family physician for every six OB/GYNs.[xxvi]

The AAFP has two courses to provide education and build skills focused on recognizing obstetrical emergencies. Advanced Life Support in Obstetrics (ALSO®) is a program that equips the entire maternity care team with skills to effectively manage obstetrical emergencies. Basic Life Support in Obstetrics (BLSO®) is designed to improve the management of normal deliveries, as well as obstetrical emergencies, by standardizing the skills of first responders, emergency personnel, and maternity care providers.

To further address this issue, the AAFP recommends that Congress pass the Rural Obstetrics Readiness Act (S. 4079), which would establish training programs to help non-specialists respond to obstetric emergencies. The bill would also provide grants for rural facilities to provide better equipment to train for and handle these emergencies and develop a pilot program for teleconsultation services so a maternal care expert can provide consulting services in an emergency.

However, training clinicians on how to deliver care during an obstetric emergency does not solve the problem. The fact remains that Americans living in rural areas are much less likely to have access to an obstetric unit than those living in urban and suburban areas. According to the Government Accountability Office (GAO) there are two main factors that affect the availability of hospital-based obstetric care in rural areas: Medicaid reimbursement rates and recruiting and retaining providers.

50 percent of births in rural areas are covered by Medicaid compared to 43 percent in the U.S. as a whole making Medicaid reimbursement rates vital to the operation of rural obstetric units. However, the reimbursement rate set by states does not cover the full cost of providing obstetric services.[xxvii] Medicaid only pays about half of what private insurers pay for childbirth-related services. Since hospital-based obstetric services can be costly to operate, it is essential to provide fair reimbursement for all births. Hospitals often rely on private insurance payments, non-obstetrical surgical care, and other supporting services to subsidize their losses from obstetric services, which leaves rural hospitals in a vulnerable financial position.

Rural hospitals also face challenges in recruiting and retaining providers. While there is a

shortage of physicians and other clinicians, it is even more pronounced in rural areas. The Health Resources and Services Administration (HRSA) estimates that the anticipated supply of OB/GYNs is expected to meet only 50 percent of the demand in rural areas.

Gaps in insurance coverage and availability of affordable care also increase the risk of morbidity and mortality, particularly during the postpartum period. We appreciate that Congress permanently extended the voluntary option for states to provide postpartum Medicaid coverage for up to a year in the Consolidated Appropriations Act of 2022. However, a permanent solution across all states is needed to ensure access to continuous care for pregnant people throughout the full, one-year postpartum period.

Current law only requires states to provide Medicaid coverage based on pregnancy status up to 60 days postpartum. As the largest single payer of maternity care in the U.S., Medicaid has a critical role to play in ensuring healthy moms and babies.[xxviii] According to the Centers for Disease Control and Prevention, more than half (53 percent) of pregnancy-related deaths occur between one week and one year postpartum, during which time many postpartum individuals lose Medicaid coverage.[xxix] The AAFP therefore continues to advocate for requiring one year of postpartum Medicaid coverage as an important way to address the disparities in maternal health and improve outcomes. Specifically, **Congress should pass the Healthy Maternal and Obstetric Medicine (Healthy MOM) Act (S.3509 / H.R. 6716) to create a special enrollment period for marketplace plans for pregnant people and require states to offer Medicaid coverage to pregnant people up to 12-months postpartum.**

Further, the AAFP recognizes that the root causes of racial and ethnic disparities in maternal morbidity and mortality include institutional racism in the health care and social service delivery system and social and economic inequities. Implicit bias is pervasive among all health care professionals and has deleterious effects on patient health.[xxx] It reduces trust, self-efficacy, understanding, and satisfaction between a patient and their physician, affecting a patient's ability to manage their health and adhere to treatment. For physicians, implicit bias limits their level of cultural proficiency, patient-centeredness, and job satisfaction.

Formal medical education and training curricula often lack content that provides a framework for identifying and mitigating implicit biases in clinical practice. Faculty who seek to incorporate this topic in training are often faced with barriers, such as the limited number of subject matter experts who can provide instruction, a lack of opportunities for participants to observe and demonstrate mitigation strategies in practice, and a lack of opportunities to engage with patients who can share experiences of encountering implicit bias in the delivery of prenatal care.

The implicit biases of health care professionals toward people of color, particularly Black women, have been shown to be a contributing factor to racial and ethnic disparities in adverse maternal health outcomes. For example, studies have demonstrated that implicit bias of health care professionals affects rates of racial and ethnic disparities in contraception use,[xxxi] access to and quality of prenatal care,[xxxii,xxxiii] and clinical decision-making[xxxiv] in the intrapartum and postpartum periods.

Strengthen and Target Graduate Medical Education Programs

As acknowledged previously, the U.S. faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate care access for patients nationwide. Though the current system excels at educating skilled physicians and physician researchers, the primary care physician shortage prevents the U.S.

from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems in other countries.

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.[xxxv] 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 Academy encourages Congress to consider ways to reimagine our country's graduate medical education (GME) system so that it better supports and invests in primary care, including an expansion of training in community-based settings. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

The AAFP supports consistent funding for GME for family medicine to ensure that new residency slots are allocated to address rural and urban imbalances, reduce physician shortages, and focus on medically underserved areas, including funding for programs such as the federal Teaching Health Center GME (THCMGE) program.

Teaching Health Centers (THCs) play a vital role in training the next generation of primary care physicians and addressing the physician shortage. To date, the THCGME program has trained more than 2,027 primary care physicians and dentists, 61 percent of whom are family physicians. Data shows that, when compared to traditional postgraduate trainees, residents who train at THCs are more likely to practice primary care (82 percent vs. 23 percent) and remain in underserved (55 percent vs. 26 percent) or rural (20 percent vs. 5 percent) communities. This demonstrates that the program is successful in tackling the issue of physician maldistribution and helps address the need to attract and retain physicians in rural areas and medically underserved communities.

However, the THCGME program's authorization expires at the end of this year, which further jeopardizes the stability of this program for its current and future residents as well as the patients they serve. Historically, the program has received piece-meal, short-term reauthorizations from Congress. This fails to consider the fact that family medicine residencies are three-year programs, meaning many medical students are dissuaded from applying to THC residencies because they have no certainty that the program will even be around long enough for them to complete their training. We have unfortunately seen this instability result in some THCGME programs accepting fewer or no new residents for next year or closing their program entirely.

For these reasons, the AAFP strongly cautions against a short-term extension. Instead, **the AAFP recommends that Congress pass the Doctors of Community (DOC) Act (H.R. 2569) to permanently authorize the THCGME program**. Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program.

We also strongly urge Congress to pass the Rural Physician Workforce Production Act (S. 230 / H.R. 834), which would provide invaluable new federal support for rural residency training to help alleviate physician shortages in rural communities. Specifically,

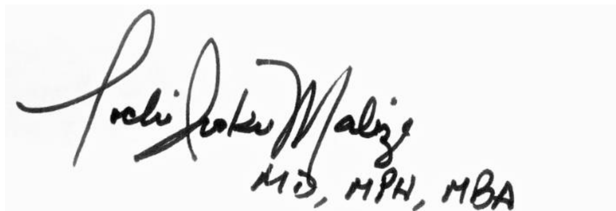
the bill would remove caps for rural training and provide new robust financial incentives for rural hospitals, including critical access and sole community hospitals, to provide the training opportunities that the communities they serve need.

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 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 is the largest single payer of GME, spending about $16 billion annually, but it does not assess how those funds are ultimately used or whether they actually address physician shortages.[xxxvi] 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.

Thank you to the Committee for its continued bipartisan leadership to improve access to rural health care. The AAFP looks forward to continuing to work with you to advance policies that will best support family physicians and the patients they serve in these communities. Should you have any questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,



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Founded in 1947, the AAFP represents 130,000 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine and the AAFP's positions on issues and clinical care, visit www.aafp.org. For information about health care, health conditions and wellness, please visit the AAFP's consumer website, www.familydoctor.org.

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