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July 29, 2022

Ms. Judith Steinberg
Senior Advisor, Office of Assistant Secretary for Health
U.S. Department of Health and Human Services
OASHPrimaryHealthCare@hhs.gov

RE: Attention: Primary Health Care RFI (87 Fed Reg 38168)

Dear Ms. Steinberg:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to provide comments on the Request for Information (RFI) regarding what the federal government could do to strengthen primary care. The AAMC strongly supports the Administration's interest in improving access to health care, advancing health equity and improving the health of the nation and we look forward to providing input into these important policy discussions.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 156 accredited U.S. and 16 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. In 2022, the Association of Academic Health Centers and the Association of Academic Health Centers International merged into the AAMC, broadening the AAMC's U.S. membership and expanding its reach to international academic health centers.

The AAMC is committed to advancing population health by promoting access to affordable, comprehensive, and culturally sensitive care, including leveraging primary care to advance health equity. As is true of all providers, primary care providers build trust and relationships with patients and families, which is one key opportunity to mitigate inequities. As part of effective health care teams, primary care clinicians can connect patients to sources of health insurance coverage, facilitate use of telehealth and other communication-based technologies to enhance access, and connect patients to community resources to address social needs. The collaboration and coordination between primary care and specialty care is important. To fully leverage primary care will require changes to existing payment practices, delivery of care reforms, and expansion of the workforce. Below are specific recommendations on ways that policymakers could strengthen primary care.

Promote the Use of Telehealth by Eliminating Barriers

Telehealth can increase access to primary care services and improve patient outcomes by enabling timely care interventions. During the public health emergency, the removal of Medicare's geographic and site of service limitations on telehealth services and other flexibilities allowed patients to maintain access to their usual source of primary care, ensuring continuity of care. Telehealth expands access to care for the frail or elderly, for whom travel to a provider or facility is risky or difficult even when there is no pandemic. Physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital admissions. Telehealth also protects patients from exposure to infectious diseases, such as COVID-19 and the seasonal flu. Given these benefits, patients and physicians have indicated that current telehealth flexibilities should continue beyond the public health emergency.

We urge Congress and HHS to make changes to legislation and regulations that will make permanent the provision of telehealth in all geographic regions and in the patient's home while ensuring that reimbursement remains at a level that will support the infrastructure needed to continue provide telehealth services. To avoid exacerbating disparities in access to primary care and other telehealth services, we also urge Congress and HHS to pay for audio-only services while improving access to broadband. Patients in rural areas, those with lower socioeconomic status, and those of certain races and ethnicities are more likely to have limited broadband access and may not have access to the technology needed for two-way audio-visual communication. Telehealth can improve the quality and comprehensiveness of patient care and expand access to care.

Encourage the Use of Provider-to-Provider Telehealth Modalities

The use of provider-to-provider telehealth modalities and peer-mentored care improves access to care and extends the expertise of the primary care workforce. The AAMC partnered with over 40 academic medical centers through Project CORE (Coordinating Optimal Referral Experiences) to pilot technology-enabled interprofessional consults ("eConsults"). In the CORE model[1], eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs. The evaluation of CORE through the CMMI HCIA project found that eConsults enabled timelier access to specialty input, led to a decrease in utilization of specialty services and costs, and resulted in positive patient and provider experience.

We encourage HHS to establish policies that support the provider-to-provider consultations using these modalities. Specifically, the AAMC recommends expanding access to eConsults by removing the coinsurance requirement for interprofessional consults, which has been a barrier to providing these important services. Patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider (99452), and one for the consulting provider (99451). Interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant, thereby making it very difficult for the consulting specialty to collect a coinsurance payment from the patient. We also urge HHS to extend the federal Medicaid match to include these physician-to-physician services.

Allow Direct Supervision of Resident Physicians via Audio/Video Communication Nationwide

During the PHE, CMS allowed virtual supervision of residents by teaching physicians, which has improved access to care. The flexibility to provide this supervision virtually has had clear benefits. However, when the PHE ends, virtual supervision will be allowed only in rural sites. The rural designation may not capture many areas of the country that are experiencing primary care and other workforce shortages. At a minimum, we urge CMS to continue to allow virtual supervision of residents in medically underserved areas in addition to rural areas to increase training opportunities and improve patients' access to comprehensive care.

Expand the Workforce

The supply of health professionals in the United States is not keeping pace with the demand for health care services. According to data from the Health Resources and Services Administration (HRSA), as of July 13,

[1] You can learn more Project CORE ("Coordinating Optimal Referral Experiences") here: https://www.aamc.org/media/25876/download?attachment

2022, 96 million people currently reside in a Primary Care Health Professional Shortage Area (HPSA) and 16,649 primary care practitioners are needed.[2] Additionally, a June 2021 report from the AAMC predicts a shortage of up to 124,000 physicians by 2034, including between 17,800 and 48,000 primary care physicians.[3] It is crucial that we invest in our country's health infrastructure by helping provide communities with the physicians they need and improved access to care. To address these shortages AAMC recommends that policymakers take the following actions:

- **Increase Medicare-Supported GME Positions:** Invest in the physician workforce in all specialties by increasing the number of Medicare-supported GME positions. The Resident Physician Shortage Reduction Act of 2021 (S. 834/H.R. 2256) is bipartisan legislation that would take steps to alleviate the physician shortage by gradually providing 14,000 new Medicare-supported GME positions over 7 years. These positions would be targeted to hospitals with diverse needs, including rural teaching hospitals, hospitals serving patients in health professional shortage areas, hospitals in states with new medical schools or branch campuses, and hospitals already training over their Medicare caps. Additionally, the House-passed Build Back Better Act (BBBA) included 4,000 new Medicare-supported GME slots that would be targeted to all specialties with an emphasis on primary care and mental and behavioral health.
- **Increase Funding for HRSA Title VII Programs.** In addition to the National Health Service Corps and the Teaching Health Center program, HRSA administers other workforce programs with a focus on primary care. The Title VII workforce development programs enhance training for future clinicians, teachers, and researchers who intend to practice as general pediatricians, general internists, family medicine practitioners, and physician assistants. These include the following programs:
    - **Primary Care Training and Enhancement (PCTE),** which encourages physicians and physician assistants to practice in primary care by supporting training programs in community - based settings.
    - **Medical Student Education Program,** which supports the primary care workforce by expanding training for medical students to become primary care clinicians, targeting institutions of higher education in states with the highest primary care workforce shortages.
- **Increase Funding for HRSA Residency Training Programs:** GME programs administered by HRSA, including Children's Hospital GME (CHGME), Teaching Health Center GME (THCGME), and the Rural Residence Program, help increase the number of primary care residents training in children's hospitals, Federally Qualified Health Centers (FQHC), and rural areas, respectively.
- **Increase Funding for the National Health Services Corps (NHSC):** The NHSC in particular has played a significant role in recruiting primary care physicians to federally designated HPSAs through scholarship and loan repayment options. Despite the NHSC's success, it still falls far short of fulfilling the health care needs or all HPSAS due to growing demand for health professionals across the country.

These programs have developed an infrastructure that can help to address the primary care physician workforce shortage. To expand and strengthen the primary care workforce, we recommend additional funding for these programs.

Promote the Use of Integrated Behavioral Health (IBH) Care Models

"Integrated behavioral health care" involves a multi-disciplinary team of medical and behavioral health providers working together with patients and their families to address the medical, behavioral, and social factors that affect health and well-being. Integrated behavioral health models seek to reduce the stigma around mental health services and expand access to care by facilitating behavioral health services within the primary or specialty care clinical setting. Academic medical centers have been at the forefront of developing and

[2] HRSA data on health professional shortage areas by discipline can be found here: https://data.hrsa.gov/topics/health-workforce/shortage-areas

[3] AAMC, The complexities of physician supply and demand: Projections from 2019-2034 (June 2021) can be found here: The Complexities of Physician Supply and Demand: Projections From 2019 to 2034 (aamc.org)

implementing a wide array of integrated behavioral health care models to meet their patients' needs and promote access to behavioral health care.[4] Despite the many evidence-based benefits of these IBH models, current payment structures, workforce training, and inadequate interoperability in health information technology are some of the challenges faced by AMCs in implementing them. The AAMC recommends that policymakers take the following steps to promote access to integrated or coordinated behavioral health care:

- **Expand Reimbursement for Integrated Patient Care Models:** The AAMC recommends that policymakers establish sustainable financing mechanisms to support IBH expansion at the practice-level. Certain integrated patient care models, such as the Collaborative Care Model (CoCM), receive payment from Medicare when billed through CoCM CPT codes, but the payment is limited to 70 minutes of integrated care in a patient's first month followed by 60 minutes in subsequent months. We recommend these codes sufficiently reimburse for the time and resources needed to provide this care and that HHS explore policies that would expand coverage and payment under this model.
- **Extend Medicare Reimbursement to all IBH Team Members:** Although the IBH multidisciplinary care team may include a diverse array of medical and mental health professionals, not all of these team members may bill Medicare for their services. For this reason, the AAMC supports policies to extend Medicare reimbursement to other licensed mental health providers such as licensed clinical social workers, mental health therapists and others. In addition, consideration should be given to funding mechanisms for certified peer support specialists and community health workers.
- **Extend Medicaid Reimbursement to Integrated Behavioral Health Models***:* Although there exist in some cases Medicare CPT codes to support IBH models, this reimbursement option does not extend to individuals covered by Medicaid in some states. The AAMC believes that Medicaid reimbursement of these models is essential to expand access for historically marginalized populations.

Pathways to Transition Primary Care from Fee-for-Service to Value Based Care

Primary care practices need opportunities to transition from a predominantly fee-for-service (FFS) model to population-based payment models that will include adjustments for health status, risk, social drivers, and other factors. A number of academic medical centers are participating in this model. The Primary Care First Model, which includes a flat payment to providers, a population-based payment, and a performance-based adjustment to payment amounts, is a good first step; however, it needs refinement based on provider participant feedback. We recommend that CMMI continue to explore the Primary Care First Model and other innovative delivery models for primary care in the future.

We thank OASH for this opportunity to provide comment on ways to strengthen primary care, and we remain committed to work with OASH on any of the issues discussed above or related topics. If you have questions regarding our comments, please feel free to contact me or Gayle Lee at galee@aamc.org.

Sincerely,

Rosha C. McCoy MD

Rosha Champion McCoy, M.D., FAAP
Acting Chief Health Care Officer, AAMC

cc: David J. Skorton, M.D., AAMC President and CEO

[4] Academic medical centers (AMCs) have implemented a wide variety of IBH models. The University of Washington, who developed the Collaborative Care Model, uses IBH throughout their primary care and specialty clinics. The University of Colorado has an extensive IBH program in their Family Practice division, but with strong senior leadership commitment is looking to expand the model system-wide. IU Health has an IBH model that supports all their primary care clinics in both rural and urban areas utilizing on-demand telehealth consults with a psychiatrist