



TO: Chairman Jason Smith, House Committee on Ways and Means

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RE: Request for Information on Improving Access to Health Care in Rural and Underserved Areas

Thank you for the opportunity to respond to your [request for information](#) on improving access to health care in rural and underserved areas. We appreciate the Committee's efforts to explore effective solutions to address this important policy issue.

The [Commonwealth Fund](#) supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable, including people of color, people with low income, and those who are uninsured.

Below we offer feedback on select comment topics within the Committee's jurisdiction. Our feedback focuses on bolstering access to and quality of primary care and behavioral health care in rural areas and is informed by research conducted by Fund-supported grantees and other peer organizations and researchers.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

The U.S. primary care system is fragile and weakening. Primary care is becoming increasingly difficult to access, and this is especially true for people living in rural America, given higher primary care workforce shortages and challenges being able to find and get to a provider due to long travel times and practice closures. The Health Services Research Administration (HRSA) has found that approximately [two-thirds](#) of primary care health professional shortage areas are now in rural areas. This has devastating consequences for rural Americans' health, as primary care is critical for preventing serious disease, promoting population health, managing behavioral health issues, advancing health equity, and making care more affordable for people.

The intense challenges facing rural primary care providers, including workforce shortages and poor access, are in large part due to financing and decades-long underinvestment in primary care overall. The portion of health care dollars going to primary care is [low and decreasing](#) over time across payers, with the U.S. spending an estimated [4-6%](#) of total health expenditures on primary care. As recent Medicare Payment Advisory Commission (MedPAC) [meetings and reports](#) confirm, primary care clinicians [are paid substantially less than specialists](#). Under the Medicare Physician Fee Schedule, due to how prices are determined by the specialty-dominated Relative Value Scale Update Committee, services that make up the core of primary care like [evaluation and management \(E&M\) are undervalued](#) and therefore not sufficiently supplied by clinicians.

Moreover, [the majority of payments](#) to primary care clinicians are made fee-for-service (FFS), which [experts increasingly agree](#) discourages team-based, coordinated care – features that are [even more critical](#) for rural areas that face higher physician shortages and lack the support of specialists and hospitals. These flaws in how and how much we pay for primary care place even greater financial challenges on rural primary care providers [that are caring for](#) older, sicker, and poorer patients.

Overcoming the nation’s rural health challenges requires we invest in primary care. National experts — including the 2021 National Academies of Sciences, Engineering, and Medicine (NASEM) report, [Implementing High-Quality Primary Care](#), the [Medicare Payment Advisory Commission](#) (MedPAC), and the Commonwealth Fund’s [Task Force on Payment and Delivery System Reform](#) — have called for increased investment and population-based payment strategies for primary care services. These payment changes would enable providers in rural areas to spend more time on patients than paperwork; enable them to deliver comprehensive care for their patients outside the confines of the fee schedule, including by identifying and addressing the social needs of rural patients; and in the long-term could even help to grow the primary care workforce in rural areas. Given that rural areas [have proportionately more older adults](#) than urban areas, Medicare plays a critical role in leading the charge. Steps to achieve this goal include:

R.1.1. Increase payment for primary care services. To address the undervaluation of primary care services, [Congress could create two fee schedules](#): one for the evaluation and management of patients — everyday diagnosis, treatment, counseling, and patient or family support (known as E&M services) — and one for everything else. A dedicated E&M fee schedule could protect against payment for primary care-related services being decreased to accommodate fee increases for other specialty services, which is required to keep the overall fee schedule budget-neutral. This could increase payments for primary care services, including in rural areas where it is much needed.

R.1.2. Develop a partial capitated per-member per-month payment model. Per-member per-month payments would provide clinicians a fixed amount per patient paid in advance, allowing clinicians to innovate, budget, and more easily integrate other kinds of care, like behavioral health or telehealth, which are essential for rural communities, into primary care. [Experts have suggested](#) that these payments should represent a 30 to 50 percent increase in current revenues, although it is not clear whether this would fully address under-compensation for rural primary care providers. As an incentive for patients to designate a primary care clinician, Congress could consider waiving any cost sharing for office visits when patients indicate their primary care clinician on an annual basis. More information about design considerations for these payments can be found [here](#).

R.1.3. Increase overall spending on primary care. [Congress could direct CMS](#) to require its payers and plans to measure and annually report the portion of total spending going to primary care, with the goal of increasing that proportion over time. Many health care systems and payers already measure the primary care spending rate. More information is needed on the ideal targets for [spending](#), particularly in rural areas.

HEALTH CARE WORKFORCE

Primary Care Workforce

Patients in rural areas of America struggle to access primary care. The [rural-urban disparity](#) in the primary care workforce is growing, with fewer primary care clinicians choosing to practice in rural areas. Given the [documented](#) relationship between access to high-quality primary care and population health outcomes, this is

a particularly concerning trend for the health of rural Americans. Strengthening and stabilizing the rural health workforce depends on supporting the primary care workforce.

There are many reasons for the rural primary care provider shortage, including that providers tend to practice where they train – and [not enough training](#) is taking place in rural or underserved areas. Federal programs have attempted to address this issue with some success; for example, the Teaching Health Center Graduate Medical Education Program (THCGME) has trained and graduated over 1,400 new primary care physicians since 2011, [a majority of whom](#) are now practicing in medically underserved areas and/or rural settings. However, [experts have said that](#) current funding levels of the major federal workforce development programs are insufficient to address the rural health workforce crisis.

To reverse these trends and rebuild the rural primary care workforce, as outlined by the NASEM report [Implementing High-Quality Primary Care](#), policymakers could consider growing and improving key federal workforce recruitment, retention, residency, and training programs:

R.2.1: Grow and Redesign the Graduate Medical Education (GME) Program. The GME program, a hospital-based residency program, is a critical lever for growing the health care workforce, particularly in rural areas and for primary care clinicians. Congress could consider adding requirements about the number of slots that must be awarded to primary care clinicians specifically to rebuild the rural primary care workforce. In addition, as recommended in the NASEM report, Congress could consider redesigning the GME program to support training of primary care clinicians in community settings, particularly in rural areas, and modifying the program to support training of interdisciplinary members of the primary care team, including physician assistants and nurse practitioners.

R.2.2: Bolster the Teaching Health Center Graduate Medical Education Program. The THCGME program is a model that trains physicians in outpatient settings, such as community health centers, in rural and underserved communities. Congress could consider reauthorizing and increasing funding for the THCGME program to grow the supply of primary care providers practicing in rural and underserved areas. THCGME [has been shown to](#) produce graduates who are more likely to work in rural areas after training, and [evidence suggests](#) it could reduce Medicare and Medicaid spending.

R.2.3: Increase Funding for Rural Residency Programs. HRSA's Rural Residency Planning and Development Program supports the creation of training programs in rural areas. Congress could consider increasing [funding for this program](#) to ensure more providers are trained in rural areas. To date, the program [has led to the creation of 38](#) new programs and hundreds of physicians training in rural communities.

R.2.4. Increase Investment in the National Health Service Corps (NHSC). Congress could reauthorize and increase funding for the National Health Service Corp, which is a critical scholarship and loan repayment program that [has been demonstrated](#) to encourage providers to practice in rural and underserved areas.

R.2.5: Promote Hybrid Payment for Primary Care. In addition to redesigning and strengthening rural training programs, to better enable the primary care workforce to deliver high-quality, comprehensive care and spend more time on patient care than paperwork, Congress can shift from the dominant approach of paying fee-for-service to offering population-based payments that enable providers to deliver the right care at the right time (see Recommendations R.1.1-R.1.2 above).

Behavioral Health Workforce

The need for quality behavioral health care in rural areas far outpaces the available workforce, owing to the maldistribution of licensed providers and uneven efforts to engage a broader range of providers in behavioral health care.

[Nearly two-thirds of rural counties](#) don't have a practicing psychiatrist and almost half of rural counties are without a psychologist, while fewer than a third of urban counties are without these licensed providers. Training programs are overwhelmingly centered in non-rural areas; given the [evidence](#) that providers tend to practice where they train, the lack of training is likely contributing to these workforce shortages.

The lower availability of behavioral health specialists in rural areas leads rural patients to turn to their primary care providers for behavioral health treatments, amplifying the importance of adequate access to primary care in rural areas.

Some rural communities engage an even [broader set of professionals to provide behavioral health care](#), including certified peer supports, social workers, and community health workers. However, [accessible training opportunities and pathways for career advancement](#) are imperative for successfully expanding and diversifying the behavioral health workforce. The Medicare program does not currently reimburse for services provided by peer supports or community health workers, and providing reimbursement for these services could expand the diversity of providers to meet beneficiaries' behavioral healthcare needs.

Expanding and diversifying the behavioral health workforce will require expanding training opportunities in rural communities and support for integration efforts through technical assistance. In addition to the recommendations for strengthening the primary care workforce, Congress could consider:

R.2.6: Expand the Health Professional Shortage Area bonus program to increase the supply of rural behavioral health providers. [Medicare provides bonus payments](#) to psychiatrists practicing in mental health professional shortage areas, but does not provide these payments to other types of behavioral health providers. Expanding the list of eligible providers could help increase the number of behavioral health providers in rural areas. This expansion of the program would be aligned with [recent Medicare regulations](#) that expanded the types of behavioral health providers [who can be reimbursed for providing services](#).

R.2.7: Provide technical assistance for states, payers, and primary care providers seeking to engage rural behavioral health paraprofessionals. Rural primary care providers and behavioral health paraprofessionals can effectively provide a range of behavioral health services, including screening, care coordination, medication-assisted treatment, and more to fill gaps in access. However, the lack of training for paraprofessionals has led to limited implementation of these models and limited [the professional advancement opportunities for paraprofessionals seeking to become licensed providers](#). Primary care practices interested in integrating behavioral health care may also lack the knowledge base or resources to do so effectively. Congress can direct various federal agencies, including CMS and HRSA, to offer robust technical assistance to rural practices looking to integrate care or engage paraprofessionals.

R.2.8. Fully Fund the Primary and Behavioral Health Care Integration Program (PBHCI). SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program supports Community Mental Health Centers through grants designed to address the physical health of adults with serious mental illness. [Evaluations](#) of the PBHCI model suggest that while there is variation in how grantee sites deploy the model, consumers treated at PBHCI clinics had improved management of select health indicators such as diabetes and cardiovascular disease. The evaluations suggest that PBHCI programs could continue to improve delivery of integrated care to adults with serious mental illness (SMI) with 'further implementation support from SAMSHA and the Technical Assistance Center.'

R.2.9: Further extend some Medicare behavioral/mental telehealth coverage changes that occurred during the COVID-19 public health emergency. [Many temporary changes were made](#) to Medicare behavioral/mental telehealth coverage during the COVID-19 public health emergency to enable Medicare beneficiaries to access the care they needed. [Some of these changes have been made permanent](#) while others have been extended through December 31, 2024. [Most experts on a panel convened](#) to evaluate the effects of these policy changes on beneficiaries viewed policies expanding Medicare telehealth coverage as likely to increase access to

services for mental health and substance use disorders. The experts expected that a higher volume of services should increase desirable outcomes and increase Medicare spending on behavioral health. However, the panelists also highlighted the importance of further research to understand the effects of the policies on subgroups of beneficiaries and the extent to which expanding telehealth policies would substitute for in-person care.

R.2.10: Support Provider Flexibilities and Task Shifting. Research supports that certain provider staffing flexibilities, such as [task-shifting](#) from behavioral health providers with higher-level credentials to those with lower-level credentials, can improve access to care without sacrificing quality. Such flexibilities could be especially impactful in rural areas, given the high prevalence of behavioral health workforce shortages. During the COVID-19 public health emergency, many temporary changes were made to Medicare behavioral/mental health staffing requirements to support beneficiaries' access to care. [Most experts on a panel convened](#) to evaluate the effects of these policy changes on beneficiaries viewed policies expanding Medicare provider flexibility as likely to increase access to services for mental health and substance use disorders.

R.2.11: Foster Adoption of Digital Mental Health Technology. [Digital Mental Health Technology](#) (DMHT) refers to evidence-based interventions that support providers as they work to detect, monitor, and treat mental health needs among their patients. DMHT in this context refers to technologies that are used in conjunction with clinical-based care to extend, rather than replace, the behavioral health workforce. These tools present opportunities to bolster the capacity of the behavioral health workforce in rural areas. However, federal regulation of DMHTs is minimal and their coverage under Medicare and Medicaid is limited. Uncertainty about reimbursement and confusion about when DMHTs warrant regulation has led to their underutilization in clinical care. To [accelerate the adoption](#) of safe and effective DMHTs, Congress could direct relevant federal agencies, such as the FDA, ONC, and SAMHSA to partner to develop more precise categories of DMHTs and clarify regulatory pathways to facilitate their safety, dissemination, and appropriate use.

Maternal Health Workforce

As of 2014, [more than half](#) of rural counties in the U.S. were considered maternity care deserts, with no hospital-based obstetric services. [More than half](#) of rural women must travel more than 30 minutes to reach the nearest hospital with obstetric services. Worsening access to maternity care [has contributed to](#) increases in maternal mortality and morbidities among rural residents, [particularly for Black women](#).

There are [several innovative models of care](#) that can help to address the rural maternity care crisis, by leveraging the existing workforce. Many regional partnerships that aim to bolster access to maternity care in their communities use versions of the hub-and-spoke model, in which obstetricians and maternal-fetal medicine specialists in urban health care organizations (the “hubs”) provide education and support to rural maternity providers (the “spokes”), who are much more likely to be family medicine physicians or nurse practitioners than obstetricians. Organizations also leverage remote monitoring systems to keep a closer eye on high-risk people between medical visits and field navigators to connect pregnant and parenting people to social and other supports. To support the maternal health workforce to deliver innovative models of care in rural communities, Congress could:

R.2.12. Promote Regional Partnerships Through Telehealth Flexibilities and Support. Congress can take steps to ensure payers are able to reimburse for audio-only visits so those without broadband access are able to participate in tele-maternity care, lift requirements for people to have in-person visits before teleconsultations, and offer startup funds to enable providers to invest in and maintain technology platforms.

R.2.13. Invest in Midwives. Midwives are licensed health care providers who offer a wide range of essential reproductive health care services. [Research consistently demonstrates](#) that when midwives play a central role in the provision of maternal care, patients are more satisfied, clinical outcomes for parents and infants

improve, and costs decrease. Midwives can help fill maternal workforce shortages in rural communities, but there remain significant payment and licensure barriers hindering them from offering services, [particularly in states](#) where more Black babies are born. Congress can help rural communities leverage midwives by ensuring sufficient reimbursement rates for midwifery services, subsidizing midwifery education and training, and encouraging states to remove unnecessary physician supervision requirements.