AMERICAN
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November 22, 2019

The Honorable Danny Davis
United States House of Representatives
2159 Rayburn House Office Building
Washington, DC 20515

The Honorable Brad Wenstrup
United States House of Representatives
2419 Rayburn House Office Building
Washington, DC 20515

The Honorable Terri Sewell
United States House of Representatives
2201 Rayburn House Office Building
Washington, DC 20515

The Honorable Jodey Arrington
United States House of Representatives
1029 Longworth House Office Building
Washington, DC 20515

Re: The Rural and Underserved Communities Health Task Force (Task Force) Request for Information

Dear Reps. Davis, Sewell, Wenstrup, and Arrington:

On behalf of the American Osteopathic Association (AOA) and the more than 145,000 osteopathic physicians (DOs) and osteopathic medical students we represent, thank you for your leadership in convening the Rural and Underserved Communities Health Task Force (Task Force).

The AOA was established in 1897 to advance the distinctive osteopathic philosophies and practice of medicine, which focus on taking a "whole person" approach to patient care. Today, osteopathic medicine is one the fastest growing health care professions in the country, with one in four medical students in the United States attending a college of osteopathic medicine. Nearly 57 percent of doctors of osteopathic medicine (DOs) practice in primary care, partnering with patients and their families throughout every stage of life, including our nation's seniors. The AOA is committed to working with Congress and the Administration to ensure that all rural and underserved Americans have access to the highest-quality, affordable care, from the health care professionals of their choice.

DOs play a critical role in increasing access to care in our country. Since 2010, the number of DOs has increased by 54 percent. Today, more than 65 percent of all DOs are under the age of 45, and if current trends continue, DOs are projected to represent more than 20 percent of the U.S. physician workforce by 2030. Additionally, more than 40 percent of active DOs practice in non-primary care specialties. DOs take a "whole person" approach to patient care by focusing on prevention and care coordination as keys to maintaining health.

Osteopathic physicians recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and care when and where they need it. With that in mind, we respectfully offer the following comments and recommendations, and look forward to expanding on these concepts in future communications with the Task

Force as you begin to develop solutions focused on improving care for patients in rural and underserved communities.

These high level comments will focus on the following areas and questions outlined by the Task Force:

1. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?
2. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?
3. Access to providers that address **oral,** behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?
4. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?

Use of telehealth/telemedicine/telemonitoring: Increasing access to and payment for telemedicine is a needed step in providing care for rural and underserved communities, whether because they reside in a Health Professional Shortage Area (HPSA), are of limited mobility, or lack reliable transportation. Approximately 23 percent of Medicare beneficiaries live in rural settings, as well as 24 percent of non-elderly Medicaid beneficiaries live in rural settings.[1] For this population, telemedicine provides a means of accessing care to those who might otherwise delay or go without treatment. To that end, Medicare payment follows strict service, originating site, and distant site restrictions.

For example, one restriction relevant to rural communities is how rural health clinics and federally qualified health centers cannot serve as distant sites although they can serve as originating sites. This is an issue that the Task Force could help address.

Additionally, originating site restrictions pose a particular challenge to the expansion of telemedicine services. Among these restrictions that pose a great challenge is the fact that an originating site must be located in both a rural census tract and HPSA, which can create access challenges for certain rural patients who are not able to access a physician or qualified health care professional due to travel limitations.

Transportation: Patients should always have the option of visiting a physician in person when they need care. Measuring distance to care, along with time of travel standards, is crucial to ensuring adequate access. As hospitals and physician offices in rural settings close due to financial strain, and networks become strained, it is more important than ever to track these measures and ensure that all patients can access the care they need. A key determinant in care access is the supply of physicians, which can be promoted through encouraging training in rural settings, promoting retention, and ensuring adequate payment for services. These three factors are crucial to ensuring the sustainability of health care services. Central to ensuring that

[1] https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/05-11-18-NRHA-Policy-Telehealth.pdf

physicians locate in rural settings is the need to incorporate it into their clinical rotations before applying for residency, and making certain these residency training programs in rural communities are funded.

Network Adequacy: Another component which is critical to access to care is strengthening health insurance network adequacy in all markets. In recent years, more patients have found themselves in plans with narrow provider networks as insurance providers reduce their network options as a way to control cost. When insurers contract with fewer providers, it limits choice and access for consumers. Additionally, narrow insurance networks reduce patients' ability to access affordable care. The growing problem of surprise medical billing is in part a byproduct of narrow insurance networks, resulting in many physicians being out of network. Strong oversight and enforcement of network adequacy requirements is needed from federal and state governments. A study published in the Journal of the American Medical Association (JAMA) in 2015 found that nearly 15 percent of health plans were specialist deficient, and beneficiaries of specialist deficient plans had high out-of-network costs. More than a quarter of these plans did not cover out-of-network services and the remainder required 50 percent cost sharing. This is especially concerning in rural areas where access to both providers and coverage options are limited.

Strengthening network adequacy standards in all markets will protect patients and lower out-of-pocket costs. Robust network adequacy standards include, but are not limited to, an adequate ratio of in-network emergency physicians, other hospital-based physicians, and on-call specialists and subspecialists being available to patients, as well as limits on geographic and driving distance standards and maximum wait times. Further, although telemedicine can help improve patient access to care, it may not be appropriate in all instances and should not be used to fulfill network adequacy requirements.

What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

The AOA believes that any federal policies developed by the Task Force must support the educational pathway of the future health care workforce in order to meet our nation's diverse patient health care needs. Ensuring a well-trained and diverse physician workforce is critical in order to provide the highest quality care and level of expertise for all rural and underserved patients. In addition to providing a well-trained workforce with sufficient primary care physicians and specialists to care for rural populations, increasing diversity in the physician workforce is important to meet health care needs by reducing healthcare disparities. This can be addressed in the recruitment and retention of a diverse medical student body and by providing training in diverse settings and populations, such as in rural areas, and to diverse populations, such as veterans and underserved populations.

Osteopathic medical education plays a key role in educating and training the future physician workforce with nearly 31,000 future physicians. As stated above, 25 percent of all medical students in the United States are currently enrolled in osteopathic medical schools – many of which are located in rural areas. Research indicates that medical students who train in community-based institutions are more likely to practice in these areas[2]. As such, we strongly support federal programs such as the Health Resources and Service Administration's (HRSA) Teaching Health Center Graduate Medical Education (THCGME) Program, the National Health Service Corps (NHSC) Program, and Title VII health professions education programs. These programs help to expand the primary care workforce in community-based settings in rural and underserved communities across the country. Data indicates that, when compared to traditional postgraduate trainees, residents who train at THCGME programs are more likely to practice primary care (82% vs. 23%) and

[2] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/program-highlights/2018/teaching-health-center-graduate-medical-education-program-2018.pdf

remain in underserved (55% vs. 26%) or rural (20% vs. 5%) communities.[3] It is clear that a well-designed THCGME program not only plays a vital role in training our next generation of primary care physicians, but helps to bridge our nation's physician shortage. In addition, THCGME programs tackle the issue of physician maldistribution by attracting and retaining physicians in rural areas and medically underserved communities. In the 2017-2018 academic year, nearly all residents in these programs received training in primary care settings and 82% of residents trained in Medically Underserved Communities.[4]

Finally, the AOA is supportive of the NHSC Loan Repayment Program, Scholarship Program, State Loan Repayment Program, and Students to Service Program. These programs support physicians and other health professionals who practice in health professional shortage areas across the U.S.

The continuation of these programs will help support increased primary care residency training programs in internal medicine, pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry and geriatrics. Expanding resident programs in these fields is critical to addressing workforce shortages and delivering health care services to the underserved and rural communities who need it most.

Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?

Osteopathic physicians fill a critical need in our nation's health care system, as many practice in rural and underserved areas. Further, osteopathic physicians are trained in a "whole person" approach to care, which involves treating all aspects of a patient's illness or injury, including the use of nonpharmacological treatment strategies for acute or chronic pain. With the focus on the whole patient as the guiding philosophy of osteopathic medicine, we believe that treatment strategies must be comprehensive and able to address each individual patient's needs.

The AOA has long supported the inclusion of substance use disorders (SUD) education for osteopathic physicians, and believes prevention and rehabilitation of persons suffering from addiction is vital in the continuation of care. Current data published in the 2015 National Survey on Drug Use and Health report, developed in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics, and others, confirms that 21.7 million people ages 12 and older were in need of substance use treatment in the reported year, however, only 2.3 million received it. Given this lack of access, overdoses from prescription opioids have dramatically increased in the United States. Today, according to the Centers for Disease Control and Prevention, 35% of all U.S. opioid overdose deaths (or 46 people per day) involve prescription opioids.

The AOA strongly supports efforts by the Task Force to increase access to care by adding new Medicare-funded graduate medical education (GME) training positions in approved addiction and pain management programs. This would be a strong step towards combating the opioid epidemic, while also addressing current and future physician shortages.

Finally, as the Task Force explores opportunities for improving oral, behavioral, and substance use treatments, we would encourage the inclusion of pain management innovations as alternatives to opioids in this discussion. We stand ready to work with the Task Force to address our nation's opioid epidemic and improve access to effective, evidence-based, non-pharmacological pain management modalities such as

[3] http://aathc.org/know-the-facts/
[4] https://bhw.hrsa.gov/grants/medicine/thcgme

osteopathic manipulative treatment (OMT)[5]. Treating pain osteopathically is a viable alternative to opioid pain management, and OMT has been recognized as an effective non-pharmacological therapy in the 2017 Federation of State Medical Boards (FSMB) guidelines as well as the 2019 American Medical Association (AMA) Opioid Task Force Recommendations.

Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?

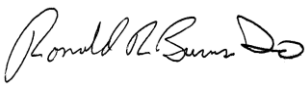
The AOA is supportive of efforts that increase access to care for rural and underserved populations, but would urge the Task Force to exercise caution and ensure that any approaches identified do not come at the expense of patient safety. We see great value in a "team" approach to medical care because the physician-led medical model ensures that professionals with complete medical education and training are adequately involved in patient care. The AOA supports funding and reimbursement structures that incentivize participation in alternative payment models that drive value and promote coordination across the care continuum. Alternative payment models play a strong role in supporting team-based primary care delivery. However, it is critical to patient safety that the care team is physicians lead.

Physician education, for DOs and MDs alike, is comprised of four years of medical school, which includes didactic study totaling upwards of 750 lecture/practice learning hours just within the first two years, plus two more years of clinical rotations performed in community hospitals, major medical centers, and doctor's offices. Postgraduate medical education (i.e. residency) includes 12,000 to 16,000 hours of supervised training over the course of 3-7 years (specialty dependent), during which time physicians develop advanced knowledge and clinical skills relating to a wide variety of patient conditions primarily within their chosen specialty. In addition to the comprehensive, three-part examination series that all physicians complete in order to obtain an unrestricted state medical license, over the course of their careers, the vast majority of physicians also complete extensive continuing medical education and rigorous board certification examinations which reflect the highest degree of achievement in their chosen medical specialty.

For these reasons, the AOA recommends that any policies that come out of the Task Force for rural and underserved populations includes access to the highest quality of physician led care.

The AOA appreciates the work the Task Force is doing, and is looking forward to the opportunity to provide future information that can be used to improve access to care and coverage for patients in rural and underserved communities. For additional information, please contact David Pugach, JD, Senior Vice President of Public Policy, at dpugach@osteopathic.org, or (202) 349 – 8753.

Sincerely,



Ronald Burns, DO, FACOFP
President, AOA

[5] Franke, H., Franke, J.-D., & Fryer, G. (2014). Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. BMC Musculoskeletal Disorders, 15, 286. http://doi.org/10.1186/1471-2474-15-286