November 29, 2019

Ways and Means Committee
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

RE: RURAL AND UNDERSERVED COMMUNITIES HEALTH TASK FORCE REQUEST FOR INFORMATION

Dear Chairman Neal and Ranking Member Brady:

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and rheumatology inter-professional team members, and the Arthritis Foundation, representing over 54 million Americans and 300,000 children with rheumatic diseases, appreciate the opportunity to provide information regarding the barriers in accessing medical care in rural and underserved communities.

Rheumatologists provide care for millions of Americans and are the experts in diagnosing, managing and treating arthritis and rheumatic diseases. These lifelong, chronic conditions include rheumatoid arthritis, lupus, gout, Sjögren's syndrome, juvenile idiopathic arthritis and hundreds of lesser-known conditions, which are expected to affect nearly 80 million Americans by the year 2040, according to the Centers for Disease Control and Prevention (CDC). According to recent data from the CDC, arthritis prevalence is at a historic high, with one in four American adults now living with doctor-diagnosed arthritis. Rheumatic disease prevalence is even higher in rural areas, where one in three adults live with doctor-diagnosed arthritis.

Rheumatic diseases including arthritis are the leading cause of disability in the United States. Early and appropriate treatment by a rheumatologist is vital to controlling disease activity, preventing and slowing progression, improving patient outcomes, and reducing the need for costly downstream procedures and care. Rheumatologists practice in every state, the District of Columbia, and Puerto Rico, and in all communities. We support polices that will make rheumatologists, other medical specialists, and life-changing treatments more readily accessible for rheumatology patients and are pleased to see the Committee put a focus on access to care in rural areas of the country.

Today, the most pressing barrier to timely access to care is a national workforce shortage of rheumatologists.[1] Increasing rates of arthritis, coupled with a dearth of new training positions for new doctors entering the rheumatology subspecialty, has led to severe doctor shortages for rheumatologic care in the United States. In fact, a 2015 study of the rheumatology workforce projects that demand for adult arthritis care will exceed supply by 138 percent in 2030.

[1] 2015 Workforce Study of Rheumatology Specialists in the United States. Available at www.rheumatology.org/portals/0/files/ACR-Workforce-Study-2015.pdf (accessed 13 September 2019).

Factors Influencing Patient Outcomes in Underserved Areas

The conversation around access often centers around insurance coverage. All Americans should be covered by continuous health insurance that encourages high quality health care including care for chronic arthritis and rheumatic diseases. Further, recognition and mitigation of barriers related to travel for patients with arthritis and other rheumatologic conditions is needed, in part due to insurance networks lacking adequate coverage for specialized services such as physical therapy and pediatric rheumatology. This is particularly important for patients living in rural and underserved areas where access to such services is limited and sometimes non-existent.

In addition, laboratory, radiology and infusion services should be readily available, unfragmented and conveniently located for patients. However, the most expansive coverage will not help a patient suffering from a disease requiring a specialist's care if there is not a specialist within an accessible distance. The aforementioned rheumatology workforce shortage threatens the health of the one in three Americans who live with arthritis and other rheumatologic diseases in rural areas. We urge the Committee to support policies that help expand the rheumatology workforce to meet the nation's growing arthritis care needs.

There is also a significant disparity in the geographic distribution of pediatric subspecialists trained to treat children in need of specialty care, resulting in many children in underserved areas not receiving timely or appropriate health care. Children and their families often face waiting lists to see subspecialists or must travel long distances to find needed care. According to a recent survey conducted by the Children's Hospital Association, appointment wait times for certain pediatric subspecialty care far exceed the prevailing benchmark of two weeks in children's hospitals. For instance, the survey showed that the average wait time is 20.8 weeks for a pediatric genetics specialist, 18.7 weeks for a developmental pediatric specialist, and 12.1 weeks for a pediatric pain management palliative care specialist. The downstream consequences of inadequate or delayed treatment for children can result in disability in adulthood.

Shortages threaten to become more severe as fewer medical students choose careers in pediatric mental health care and pediatric subspecialties. There are three primary economic disincentives that discourage medical students from pursuing careers in pediatric subspecialties: (1) additional training beyond their primary residency training of 2-3 years on average, (2) high loan debt due to longer training;[2] and (3) average Medicaid reimbursement that is 30 percent less than Medicare. In addition, the shortage of pediatric subspecialists is compounded both by an aging physician workforce, where the mean age of pediatric subspecialists exceeds 50 years,[3] and by the growing number of children in the United States. In 2016, there were 73.6 million children in the United States under the age of 18. According to the Census Bureau, that number is expected to grow by approximately 5 million by 2050, increasing demand for pediatric health care services.[4]

Timely access to pediatric subspecialists is essential. Longer lag times between symptom onset and treatment may not only result in poorer outcomes but also in greater costs to patients and the health care system. Support for pediatric subspecialty loan repayment will help ameliorate shortages by providing a financial incentive for trainees to choose careers in pediatric subspecialties.

---

[2] Frintner MP, Mulvey HJ, Pletcher BA, Olson LM. "Pediatric Resident Debt and Career Intentions." Pediatrics. 2013. Rochlin JM, Simon HK. "Does Fellowship Pay: What is the Long-Term Financial Impact of Subspecialty Training in Pediatrics?" Pediatrics. 2011 Feb;127(2):254-60.

[3] Werner RM, Polsky D. "Comparing the Supply of Pediatric Subspecialists and Child Neurologists." Journal of Pediatrics. 2005 Jan; 146(1):20-5.

[4] United States Census Bureau. 2017 National Population Projections Tables. "Table 2. Projected age and sex composition of the population." https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html. Accessed January 4, 2019.

Policies to Address Workforce Shortages in Underserved Areas

Training Medical Professionals in Underserved Communities

Graduate medical education programs should be expanded to train more adult and pediatric rheumatologists and encourage physician assistants, nurse practitioners and nurses to obtain specialized training in rheumatology. One suggestion would be to expand Medicare's support for Graduate Medical Education (GME), which is limited by a cap on the number of Medicare-supported residency positions at each institution based on the number of residents the institution was training in 1996. These caps were imposed when Congress passed the Balanced Budget Act of 1997. Today, even if a teaching hospital is currently training many more residents than it did in 1996, Medicare will make payments only for the number of residents that the institution was training in 1996. Such arbitrary caps on training funding at a time when the patient population continues to expand exacerbates the issue of access to care in underserved communities.

Rural hospitals received a cap based on 130 percent of the number of residents training at that time, which left them some room to grow their training programs, but not enough. Data from the American Medical Association Physician Masterfile shows that 56 percent of family medicine residency graduates practice within 100 miles of where they completed their residency training. Furthermore, 39 percent locate within 25 miles, and 19 percent stay within five miles of their training program.[5] Policies creating opportunities to train medical professions in these underserved communities seem to be the most direct and immediate way to interject these in-need patient populations with more providers.

International Medical Professionals

Access to rheumatologic care is critical for people living with diseases like rheumatoid arthritis to manage pain and avoid long-term disability. Unfortunately, recent workforce studies indicate a growing scarcity of rheumatologists, particularly in more rural and less populated portions of our nation. The access crisis created by this shortage of rheumatologists is compounded by historically high rates of arthritis and recent immigration policy that makes it harder for international medical residents and doctors to train and practice in the U.S.

The ACR supports open interchange among clinicians, scientists, and students around the world for the purposes of advancing education, training, scientific work, and the provision of quality healthcare. Policies like the Conrad State 30 program allow international doctors to remain in the U.S. upon completing their residency under the condition that they practice in rural and underserved communities. Such commonsense legislation makes it easier to attract and retain international rheumatologists to practice in medically underserved areas of the United States. Furthermore, the ACR supports the H-1B visa program considering the needs of these communities to allow for international physicians to continue to enter the United States to care for underserved patients. Specifically, the ACR supports the USCIS exempting medical professionals from any suspension or limitation of H-1B visa priority processing.

[5] https://www.aafp.org/news/education-professional-development/20131120rgcfmgrads.html

Loan Repayment Assistance

When an individual chooses to become a physician they often take on life-altering (and choice-limiting) debt to obtain that education. This debt may deter potential physicians from the profession at every level of education. Once the debt is acquired, it limits the options of those individuals who may prefer to practice in a smaller community, but do not have the means to establish a practice there. To ease this burden, we support policies that reduce the amount of these loans and target loan relief for medical professionals who choose to serve those most in need.

There are fewer than 450 board-certified, practicing pediatric rheumatologists across the country. We urge Congress to take two steps to bolster the pediatric rheumatology workforce:

- Reauthorize and fully fund the Pediatric Subspecialty Loan Repayment Program (Section 775 of the Public Health Service Act), which would provide up to $35,000 in loan repayment per year for up to three years in exchange for practicing in a rural or underserved area. This section was originally authorized in 2010 but was never funded by Congress before the authorization lapsed in 2014. We were pleased to see the EMPOWER for Health Act (H.R. 2781) included a provision to reauthorize this program; the bill passed the House by voice vote in October. Incentivizing pediatric subspecialists to practice in underserved areas through loan repayment will reduce the burden of pursuing subspecialty training and provide needed access to care and treatment.

- Reauthorize language directing the Secretary of Health and Human Services to evaluate whether the number of pediatric rheumatologists is sufficient to address health care needs of children diagnosed with arthritis and recommend strategies to help address the shortfall. The required report was neither completed nor submitted to Congress nearly two decades ago. The provision is still vitally important to this day. We strongly urge the Committee to update this language and include it in legislation. It is long overdue for Congress to have the latest information about children diagnosed with rheumatic diseases.[6]

The REDI Act (H.R. 1554), which the ACR supports, would ease the burden of medical education loans by amending the Higher Education Act to defer the accumulation of interest on student loans for borrowers while they serve in a medical internship or residency program. Often, professionals owe more on a student loan even after making payments on the loan due to the accrual of interest. Preventing the beginning of that accrual until after these students get through a low-paying residency and to allow for specialty training in the areas of need which would make careers in medicine more accessible.

Once a physician decides to practice in an area which is underserved and has less of a medical services structure, health care policies should be designed to allow providers to run viable medical practices in a plurality of settings with a variety of organizational structures including rural and urban environments, small and large practices, single and multispecialty groups, academic centers, solo practices, and practices affiliated with and independent of other health systems.

We are dedicated to ensuring that rheumatologists, interprofessional team members, and patients everywhere in the United States have access to continuous high-value and high-quality care. We appreciate the opportunity to share our comments about barriers in accessing care in underserved

[6]https://www.law.cornell.edu/uscode/text/42/294p

communities and look forward to serving as a resource to you and to working with the committee as policies develop from these comments. Please contact Lennie Shewmaker, J.D., Director of Congressional Affairs at the American College of Rheumatology, at LShewmaker@rheumatology.org, or Vincent Pacileo, Director of Federal Affairs at the Arthritis Foundation, at VPacileo@arthritis.org, if you have questions or if we can be of assistance.

Sincerely,

Elizabeth B. Solow, MD
Chair, Government Affairs Committee
American College of Rheumatology

Anna Hyde
Vice President, Advocacy and Access
Arthritis Foundation