



Primary Care for America

December 6, 2021

The Honorable Joseph R. Biden, Jr.
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear President Biden and Secretary Becerra:

Primary Care for America, a diverse collection of 13 health care organizations, caring for infants and children, adults and seniors in the Medicaid, Medicare, Marketplace, and commercial markets in every county across the nation. COVID-19 has laid bare the stark inequities that many communities experience leading to poor outcomes and in many cases, death. These inequities occur not only in underserved areas but impact racial and ethnic communities across socioeconomic status.

Our collaborative consists of organizations across the country leading efforts to address these disparities wherever they exist. We comprise physicians, community health centers, services, and products, with a commitment to deliver high quality, accessible primary care to all patients, especially those who are historically underserved and systemically disadvantaged.

The national discourse appropriately recognizes the important role that primary care plays in identifying and addressing social needs that have a great impact on overall health such as food access, transportation, housing, and behavioral health resources. Research has shown that greater access to primary care is associated with better health outcomes.^[1] However, for these efforts to be effective, primary care practices must have the appropriate resources to address the unique needs of their diverse patient populations.

We urge your administration to consider the following recommendations to ensure access to care and support the physician workforce as we continue to deal with the COVID-19 pandemic. Key barriers in current payment models inadvertently drive health inequities and must be addressed.

- Existing methodologies for calculating costs and savings associated with health programs and policies may not account for long-term positive impacts of access to comprehensive, longitudinal primary care. The benefits of person-centered primary care often accrue over several years and long past a typical model's evaluation period, therefore the positive impact of accessible primary care is not accounted for when determining the cost of a program or the estimated savings to the federal government.
- Payment models do not account for savings across government programs, particularly when they are administered by other federal agencies. These limitations undermine the expansion of successful programs meant to mitigate the systematic and root causes of health inequities due to the projected cost.

- Alternative payment models must be designed with an eye toward addressing health inequities by employing robust risk adjustment to account for individual factors and social drivers of health to level the playing field. Measurements should be risk-adjusted to include populations placed at increased risk of negative health outcomes and more accurately isolate and analyze population needs. Appropriate measure design will ensure that they are not used as a method of levying financial penalties but as a mechanism to surface gaps in needs and resources at the entity, community, and population level.

To achieve optimum results, it is essential that we use technological tools to comprehensively address the needs of all communities. Artificial intelligence and machine learning hold incredible potential to transform the practice of medicine and optimize patient care, but if not integrated thoughtfully, technology has the potential to exacerbate existing health inequities due to embedded biases in some algorithms and assumptions.^[2] Additionally, technology must enable real-time insights on community health needs, which will require standardization and accessibility. Population health across a geographic underserved community also requires robust analytic capabilities accessible to primary care providers on a real time basis. The investment in such models along with care managers are crucial to managing beneficiaries in value-based arrangements.

Currently, most health data collection efforts at the federal, state, and local level are focused on five broad racial groups, two ethnicities, and variable descriptors for LGBTQ+ people. Without specific indicators, these populations may not receive adequate consideration in budgeting processes and resource allocations, resulting in further disadvantage. Aggregate datasets that can be accurately stratified by race and ethnicity, as well as sexual orientation and gender identity, are vital tools for physician practices and health care organizations to identify disparities within their patient panel and work to address them. The same is true for data collection and reporting for public health purposes. We urge the Administration to support robust data collection to get a full and accurate view of existing disparities.

The COVID-19 pandemic has also highlighted how disparate access to broadband, smartphones, and other digital devices and infrastructure can exacerbate existing health and financial disparities. Millions of Americans rely on broadband and existing devices to access preventive health services, mental and behavioral health care, education, job and housing resources, and public health information. The recently enacted Infrastructure Investment and Jobs Act will provide vital support for improvements in broadband infrastructure and expand access. It is estimated that 42 million Americans don't have the ability to purchase broadband internet service.^[3] And rural Americans are 10 times more likely to lack broadband access than their urban counterparts.^[4] Without broadband access, many individuals living in Tribal, rural, and urban areas are unable to connect with their physicians via telehealth to receive needed care. Given that access to telehealth services can help remove other barriers to care, such as transportation or childcare, improving broadband access could help advance health equity. Broadband is also needed to address other social drivers of health, such as education, safe housing, loneliness, and employment, or applying for public programs that provide financial assistance and health insurance.

In addition to addressing the financing models and the role of technology, the importance of a diverse physician workforce cannot be overstated. Physicians who understand their patients'

languages and understand the larger context of culture, gender, religious beliefs, sexual orientation and socioeconomic conditions are better equipped to address the needs of specific populations and the health disparities among them. Several studies show that racial, ethnic, and gender diversity among physicians promotes better access to health care, improves health care quality for underserved populations, and better meets the health care needs of our increasingly diverse population.^{[5],[6]} While primary care specialties fare better than other specialties in representation of racial and ethnic minorities in the workforce, the entire physician workforce lags significantly behind the racial and ethnic diversity of the U.S. population. Today, Black and Hispanic Americans account for nearly one-third of the U.S. population, but just 11 percent of physicians.^{[7],[8]} We urge you to invest in efforts to strengthen the physician pipeline as early as middle school, diversify the physician workforce to improve access to health care, reduce spending, and better meet the needs of our diverse population.

Another important consideration of addressing health equity is strengthening the Medicaid program. It plays a particularly vital role in providing coverage to children, pregnant women, rural residents, individuals with disabilities, as well as Black, Indigenous, Hispanic, and other people of color. More than 30 percent of Black, Indigenous, and Hispanic adults and children have Medicaid coverage.^[9] Improving coverage and affordability of primary care has significantly reduced racial and ethnic disparities in care utilization and access.^[10] However, the odds of residing in a physician shortage area are much higher for predominantly Black neighborhoods.^{[11],[12]} Given the significant growth in Medicaid eligibility and enrollment over the last year, federal action from this Administration is needed to improve and secure long-term access to primary care for Medicaid beneficiaries. Today, Medicaid physician payment rate is, on average, 66 percent of the Medicare rate for primary care services, but it can be as low as 33 percent of the Medicare rate depending on the state. Increasing Medicaid payment rates for primary care services to at least Medicare levels would ensure clinicians have adequate resources to care for Medicaid patients and alleviate barriers to care for patients who are most in need. Federal financial support and oversight, including implementing payment parity and a federal minimum Medicaid access standard, would help ensure primary care physicians can accept new Medicaid beneficiaries and spend as much time with the patient as they need without sacrificing the financial stability of their practice.

Currently, the United States is the only industrialized nation where maternal deaths are on the rise. According to the Centers for Disease Control and Prevention, approximately 700 pregnancy-related deaths occur in the U.S. each year and 60 percent of these deaths are preventable.^{[13],[14]} What's more, Black women are three times more likely to die from a pregnancy-related complication than non-Hispanic White women; Indigenous women are more than twice as likely to die from a pregnancy-related complication than non-Hispanic White women.^[15] These outcomes and disparities are unacceptable. A strong primary care infrastructure supports women's health from preconception through the postpartum period and beyond, ensuring a healthy start to pregnancy and prioritizing health and wellness throughout the lifespan.^[16] Improved access to primary care for birthing patients is also associated with decreased infant mortality and healthier birth weights for babies.^[17]

Primary Care for America stands ready to partner with you to root out health inequities wherever they exist. Our members are in every county across the country; committed to creating a system that delivers high quality health care to all people regardless of the zip code they reside in.

If you or your staff have any questions about our comments, please contact Stephanie Quinn at squinn@aafp.org.

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The Honorable Chiquita Brooks-LaSure, Administrator of the Centers for Medicare and Medicaid Services

The Honorable Diana Espinosa, Acting Administrator of the Health Resources and Services Administration

The Honorable Rochelle Walensky, Director of the Centers for Disease Control and Prevention

The Honorable Vivek Murthy, Surgeon General of the United States

The Honorable Rachel Levine, Assistant Secretary of Health for the Department of Health and Human Services

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Primary Care for America (PCfA) is a collaboration focused on demonstrating the value of primary care, the need for increased primary care investment and the importance of innovation in primary care delivery and payment models. PCfA is comprised of a diverse group of key partners in the American health care industry: agilon health, Aledade, American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, Catalyst Health Network, ChenMed, Elation Health, Everside Health, MDVIP, National Association of Community Health Centers, One Medical and VillageMD. For more information about Primary Care for America, visit primarycareforamerica.org.

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