National Rural Health Association

August 1, 2022

Admiral Rachel L. Levine, MD, FAAP
Assistant Secretary of Health
U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 716G
Washington, DC 20201

Dear Assistant Secretary Levine,

The National Rural Health Association (NRHA) is pleased to offer a response to the Department of Health and Human Services' (HHS) Request for Information on its Initiative to Strengthen Primary Care. Primary care is essential to the health and well-being of rural residents, and we thank HHS and the Office of the Assistant Secretary (OASH) for its focus on bolstering primary care.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, rural health clinics, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Primary care is the foundation of the rural health safety net. It is an essential access point to health care for rural residents, and it serves as the first point of entry into the health care system.[i] Primary care involves disease prevention, health promotion, patient counseling, and diagnosis and treatment of chronic or acute illnesses.[ii] Regular access to primary care is linked to better overall health outcomes.

Primary care access is incredibly important for rural patients as the average rural resident is older, sicker, and poorer than their urban counterparts. Rural health outcomes consistently lag behind urban health outcomes. One measure of health outcomes is life expectancy. In 2019, the age-adjusted death rate was 20 percent higher in rural compared to urban areas.[iii] Life expectancy is impacted by many factors, but studies indicate that primary care physician density is associated with reduced mortality.[iv] Rural life expectancy could be improved through a robust primary care infrastructure.

Supporting broader rural heath infrastructure consequently uplifts primary care. Unfortunately, the reverse is also true. For example, hospital closures mean that communities lose their primary care physician. Since 2010, 140 rural hospitals have closed. Two other touchpoints for primary care are Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), however, there are 17 million residents in rural counties without an RHC and 15 million without an FQHC.[v] Altogether, there are over

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660,000 residents in rural counties without an acute care hospital, RHC, or FQHC.[vi] This disincentivizes residents from seeking primary care as they must travel outside of their home county.

Understanding the primary care needs of a community is an important step in strengthening primary care services. OASH and HHS should consider a pilot program that monitors what services patients in a service area are receiving. Individuals in charge of deciding what services are offered at a hospital could use this data to inform what primary care services are most beneficial to their community. Using zip code level data, a pilot program can survey and report to hospital decision makers what services patients in a particular area are receiving. Informed decision making can lead to better meeting patient primary care needs and reducing hospital costs.

WORKFORCE

Have a robust healthcare workforce poses one of the major barriers to primary care access. Startingly low numbers of primary care physicians serve rural areas. In 2013, there were 55.1 primary care physicians per 10,000 residents in rural counties, down from 62 per 10,000 in 2008.[vii] In metropolitan counties, residents enjoyed 79.3 primary care physicians per 10,000 residents in 2013. Trends in the larger rural health workforce decline can be contributed to the aging rural health care workforce and lack of provider willingness to live and work in rural areas.

HHS should take the following actions to strengthen the primary care workforce:

- Expanding existing scopes of practice and allowing practitioners, like physician assistants (PA), nurse practitioners (NP), and clinical nurse specialists (CNS) to practice at the top of their license would further alleviate the dearth of rural primary care practitioners. PAs and NPs have been integral in mitigating the primary care physician workforce. For example, 39% of PAs in rural areas practice primary care, compared to 21% in urban areas.[viii]
  - Remove unnecessary burdens that prohibit PAs and NPs from providing needed care to patients. For example, Medicare requires a physician to certify the need for diabetic shoes and requires that a physician order diabetic shoes while a PA or NP may manage all other aspects of care for a diabetic patient. Further, full authority should be given to NP/PAs to order Medical Nutrition Therapy (MNT).
  - Allow NPs and PAs to treat and evaluate injuries related to worker's compensation claims without physician oversight.
  - Align scope of practice restrictions under Medicare for RHCs with state scope of practice laws.
- Address challenges in recruiting other practitioners, like PAs and NPs, to practice in primary care versus specialties through financial incentives like higher reimbursement and tax credits.

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- Consider new pathways into primary care, making care accessible outside of traditional office, hospital, and clinic settings. One community-based entryway into primary care is the community paramedicine framework. California piloted a community paramedicine program starting in 2014 and serves as a model example for how this could take place

PAYMENT

Low Medicare and Medicaid reimbursement rates for rural generalist and outpatient primary care services, combined with lower-than-average volume and higher than average patient complexity, limits rural primary care providers reinvestment in needed updates to infrastructure, operations, and engagement in population health strategies. Fee-for-service payment is predominant in the rural primary care payment system, resulting in office visit-centric and non-team-based care, rewarding episodic care that is too often brief and incomplete[ix]. It is critical that HHS develop new value-based payment models support coordinated, integrated primary care rewarding high quality, positive patient experience, and/or lower cost. [x]

- Create pathways to rapidly transition from a predominantly fee-for-service model to a predominantly population-based prospective payment (hybrid) model coupled with up-front and ongoing investments and guardrails to ensure that patients and communities most affected by health and health care inequities, and the primary care clinicians and teams that care for them, realize the benefits of a higher-value health system.
- Payment levels should include significant differentials for practice in chronically underserved areas, including those in rural and frontier locations, as well as adjustments for health status, risk, social drivers of health and social risk, historic under-investment, and other elements.

At the onset of the COVID-19 pandemic, RHCs and Federally Qualified Health Centers (FQHC) were granted telehealth distant-site status under Medicare for the first time through Section 3704 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. While distant-site status for RHC/FQHCs under Medicare is needed change, the current payment methodology for these services is also inadequate for several reasons. The reimbursement for telehealth services is currently a flat rate of $92.00 per telehealth visit, far below the RHC upper payment limit. Further, the singular code given to RHC/FQHC telehealth services does not accurately capture the full scope of work being provided. Not having a true reflection or payment of the work being provided via telehealth in rural areas creates leads to a disparity in investment and utilization for hard-to-reach rural communities.

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- Modify telehealth reimbursement for RHC/FQHC so that these critical rural providers can continue utilizing telehealth technologies, and that rural patients can take part in telehealth services at the same rate as their urban counterparts.

BEHAVIORAL HEALTH AS PRIMARY CARE

Recognizing behavioral health as part of primary care would strengthen primary care as a whole. Across rural America, there is a behavioral health crisis due to accessibility challenges and geographic barriers, technology barriers impeding access to services via telehealth, lack of mental health professionals in rural areas, and stigma.[xi] Integrating behavioral health services into primary care would work to lessen the impact that these factors have on the state of rural behavioral health and uplift behavioral health as a needed service. NRHA recommends that HHS:

- Support co-location of mental health and substance use treatment with physical health services at hospitals, clinics, community health agencies, and tribal centers and provide support for interprofessional coordination and collaboration.
- Allow community health workers to be credentialed and reimbursed for services, including licensed professional counselors and MSWs.
- Consider integrating social determinants of health and behavioral health into primary care through use of Z codes. HHS should consider payment incentives to help rural providers initiate using Z codes to reduce administration barriers.
- Allow RHCs to go above 50% limit on mental health services when the RHC is located in a Mental Health Health Care Professional Shortage Area and/or redefine the RHC encounter to include mental health services as a primary care service.

NRHA would like to echo and incorporate responses from the National Organization of State Offices of Rural Health (NOSORH), the Primary Care Collaborative, the RUPRI Health Panel, the National Association of Community Health Centers (NACHC), the American Association of Nurse Practitioners (AANP), the American Academy of Physician Assistants (AAPA), and the American Academy of Family Physicians (AAFP).

We thank OASH and HHS for the opportunity to submit a response to this RFI and for their continued commitment to strengthening primary care. If you have any questions or would like more information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

National Rural Health Association

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[i] https://www.ruralhealthinfo.org/topics/healthcare-access#primary-care
[ii] https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccesstoPrimaryCare.pdf
[iii] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Decreasing-Rural-Life-Expectancy-Policy-Brief-2022.pdf
[iv] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Toward-a-Sustainable-Rural-Health-Workforce-Policy-Brief-2022.pdf
[v] https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccesstoPrimaryCare.pdf
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[vii] https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccesstoPrimaryCare.pdf and https://srhrc.tamhsc.edu/docs/rhp2020-volume-1.pdf#page=30
[viii] https://www.aapa.org/news-central/2018/06/pas-rural-locations-ready-meet-primary-care-needs/
[ix] https://rupri.org/wp-content/uploads/20180725-Primary-Care-The-Foundation-for-a-High-Performance-Rural-Health-Care-System.pdf
[x] https://rupri.org/wp-content/uploads/20180725-Primary-Care-The-Foundation-for-a-High-Performance-Rural-Health-Care-System.pdf
[xi] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/NRHA-Mental-health-in-rural-areas-policy-brief-2022.pdf

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