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AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

October 9, 2019

Tom Morris, MPA
Associate Administrator
Federal Office of Rural Health Policy
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

RE: Rural Access to Health Care Services Request for Information

Dear Mr. Morris:

The American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) on behalf of the physicians, medical students, and colleges of osteopathic medicine (COMs) we represent, appreciate this opportunity to submit comments on the Health Resources and Services Administration (HRSA) Rural Access to Health Care Services Request for Information (RFI). The AOA represents more than 145,000 osteopathic physicians (DOs) and medical students, promotes public health, encourages scientific research, serves as the primary certifying body for DOs, and is the accrediting agency for osteopathic medical schools. AACOM represents all 35 accredited COMs—educating nearly 31,000 future physicians, 25 percent of all U.S. medical students—at 57 teaching locations, in 32 U.S. states. Both organizations represent, osteopathic graduate medical education professionals and trainees at U.S. medical centers, hospitals, clinics, and health systems.

As organizations representing osteopathic physicians, we believe it is crucial that patients can access high-quality care when and where they need it, regardless of where they live across the country. Osteopathic physicians fill a particular need in our health care system, as they practice disproportionately in rural areas, giving them a unique perspective on the challenges of delivering care in this setting. Please find our feedback on the questions within the RFI outlined below.

1. **What are the core health care services needed in rural communities and how can those services be delivered?**

Telemedicine:
The AOA believes that among the core services that patients should have access to in rural settings is telemedicine. While this is a method of care delivery for certain services, we believe that patients in rural settings who do not live near a certain physician or qualified health care professional should be able to access medically necessary services through telecommunication technology, when appropriate. While the Centers for Medicare & Medicaid Services (CMS) currently provides payment for certain telemedicine services, access is greatly restricted across federal programs by factors that include reimbursement rates, site eligibility, and state laws.

Currently, telemedicine services that are reimbursed by state Medicaid programs vary significantly by state, and 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. 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 Health Professional Shortage Area (HPSA), which can create access challenges for certain rural patients that need to travel to access a physician or qualified health care professional.

In addition to the aforementioned limitations to the expansion and utilization of telemedicine services, the AOA notes the limiting factor that state medical licensure has on the ability to deliver telemedicine services. Currently, physicians must be licensed in the state in which the patient resides to provide telemedicine services, and thus, artificially limits the number of physicians who could be available to provide telemedicine services to any given patient population. In fact, this limitation helps to perpetuate the physician workforce shortage in rural America.

Ultimately, we believe that telemedicine has the potential to improve access to care and that it should be considered a core health care service. Approximately 23 percent of Medicare beneficiaries live in rural settings, and 24 percent of non-elderly Medicaid beneficiaries live in rural settings.[1] Compounding the access challenges created by the restrictions on telemedicine within federal programs is the fact that even sites that are eligible to deliver telemedicine services do not necessarily do so. Expanding access to this mode of care delivery, measuring patient access, and measuring its use by rural facilities will help promote expanded access to health care services, especially to those who live in remote settings or have limited mobility. Monitoring of access and outcomes may also promote alignment of covered services and payment rates across programs and insurers.

Vision Services:
Access to vision services remains a persistent challenge in rural communities and results in preventable vision impairments. The National Rural Health Association notes that rural areas lack vision care providers, and only 30 percent of FQHCs provide eye care services.[2] HRSA should consider vision care a core service, measure access to providers, and ensure that rural communities have an adequate supply of providers.

2. **What are the appropriate types, numbers, and/or ratios of health care professionals needed to provide core health care services locally for rural populations of different compositions and sizes?**

Osteopathic Medical Education and Investing in the Future Physician Workforce:
Federal policies must support the educational pathway of the future health care workforce in order to meet the nation's diverse patient health care needs. The AOA and AACOM reiterate our strong support

[1] https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/05-11-18-NRHA-Policy-Telehealth.pdf
[2] https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents-(ME)/Archive-(ME)-(1)/PolicybriefPrimaryEye.pdf.aspx?lang=en-US

for the continued efforts of HRSA as it works to improve access to and delivery of health care services, particularly in rural communities, by ensuring a well-trained and diverse physician workforce. In addition to access to care, this is a critical aspect of a strong and sustainable health care system. However, recent studies have identified shortages in specific physician specialties and highlighted rural areas as more likely to experience such shortages.[3] 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. 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. Moreover, we urge HRSA to continue to work collaboratively with stakeholders and to dedicate its resources to enhancing training capacity and strengthening partnerships between academia, health delivery systems, and faith-based and community organizations.

Osteopathic medical education (OME) plays a key role in educating and training the future physician workforce with nearly 31,000 future physicians, 25 percent of all U.S. medical students, currently enrolled at the nation's osteopathic medical schools – many of which are located in rural areas. In fact, colleges of osteopathic medicine (COMs) have a standing commitment to and focus on training primary care physicians, which mirrors the special commitment osteopathic physicians have in providing primary care, particularly to the nation's rural and underserved populations. Also, accreditation requirements for osteopathic medical schools mandate that each school provide medical care to the community where its students train, and the current OME model links the osteopathic medical schools' training to the communities where they teach students. This is especially important as our nation faces a growing physician workforce shortage.

Based on research, which indicates that medical students who train in community-based institutions are more likely to practice in these areas[4], AACOM continues to support federal programs that expand the participation of community-based institutions. As such, we strongly support federal programs such as HRSA's Teaching Health Center Graduate Medical Education (THCGME) Program, the National Health Service Corps (NHSC) Program, and Title VII health professions education programs. These programs seek to expand the primary care workforce in community-based settings in rural communities across the country.

HRSA should strongly support the long-term sustainment of the THCGME Program which provides funding to support primary care medical and dental residents training in community-based settings. The majority of currently-funded medical residency programs are osteopathic or dually-accredited (DO/MD). Currently, there are more than 700 residents being trained in 56 HRSA- supported THC residencies in 23 states. According to HRSA, physicians who train in teaching health centers (THCs) are three times more likely to work in such centers and more than twice as likely to work in underserved areas. Additionally, a recent study[5] found that the THCGME program could yield up to $1.8 billion in public program savings ($1.5 billion in Medicaid savings and $284 billion in Medicare

[3] https://www.graham-center.org/rgc/publications-reports/publications/one-pagers/unequal-distribution-2013.html
[4] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/program-highlights/2018/teaching-health-center-graduate-medical-education-program-2018.pdf
[5] http://gwhpmmatters.com/sites/default/files/2019-03/Examining%20the%20Cost%20Effectiveness%20of%20Teaching%20Health%20Centers%20%28Chen%2C%20Ku%2C%20Regenstein%2C%20Mullan%29%20Mar%2021%2C%202019.pdf

savings) over the course of five years, from 2019 to 2023. The continuation of this program is critical to addressing primary care physician workforce shortages and delivering health care services to underserved communities most in need.

The NHSC -- including the Loan Repayment Program, Scholarship Program, State Loan Repayment Program, and Students to Service Program -- supports physicians and other health professionals who practice in health professional shortage areas across the U.S. In fiscal year 2019, a field strength of more than 11,400 primary care clinicians are providing services nationwide in health professional shortage areas, many of which are located in rural communities.

We encourage HRSA to continue to prioritize Title VII health professions education programs, as authorized under the *Public Health Services Act* (42 U.S.C. Chapter 6A) and administered through the agency. These programs are critical to support the training and education of health practitioners to enhance the supply, diversity, and distribution of the health care workforce, acting as an essential part of the health care safety net and filling the gaps in the supply of health professionals not met by traditional market forces. Title VII programs are the only federal programs designed to train primary care professionals in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce. Specifically, we support and recognize the importance of the Primary Care Training and Enhancement Grant Program, the Rural Physician Training Grants, the Centers of Excellence, the Health Careers Opportunity Program, the Scholarships for Disadvantaged Students Program, the Geriatric Education Centers, and the Area Health Education Centers.

Additionally, interprofessional education (IPE) for collaborative practice is an important aspect of medical education and should be considered by HRSA as it develops policy surrounding health care services for rural communities. Interprofessional team-based care is a major consideration in the future of quality patient care. This statement is in alignment with the considerations from the Interprofessional Education Collaborative (IPEC)[6]; the American Osteopathic Association Commission on Osteopathic College Accreditation standards; Association of American Medical Colleges' Entrustable Professional Activities; an Institute of Medicine report, *Measuring the Impact of IPE on Collaborating Practice and Patient Outcomes*; and Joint Accreditation for Interprofessional Continuing Education.

AACOM is also an inaugural partner of the IPEC, which was formed to promote and encourage constituent efforts to advance interprofessional learning experiences to help prepare future health professionals for enhanced team-based care of patients and improved population health outcomes. IPEC was founded by the Association of American Medical Colleges, American Dental Education Association, American Association of Colleges of Pharmacy, American Association of Colleges of Nursing, the Association of Schools of Public Health, and AACOM, and has developed a widely-accepted set of competencies in interprofessional education.[7]

Furthermore, we support initiatives that facilitate communication among patients and health professionals to help ensure culturally competent care. This includes support for efforts to expand

[6] https://www.ipecollaborative.org/

[7] https://nebula.wsimg.com/2f68a39520b03336b41038c370497473?AccessKeyId=DC06780E69ED19E2B3A5&disposition=0&alloworigin=1

outreach to culturally diverse populations, including enhancing research efforts and improving health care options in communities where the incidence of certain health care conditions is more prevalent than in the population as a whole. When appropriate, HRSA should consider incorporating patient focus groups to obtain their perspective on the best way to facilitate communication.

3. **What other factors are important to consider when identifying core health services in different rural communities, such as current and projected population size, distance to the nearest source of care, availability of telehealth, and sustainability of services?**

Distance to care:
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 physicians located in rural settings is making sure that medical students are able to experience clinical rotations in these settings before applying for residency, and that residency training programs in rural communities are funded.

Sustainability:
Perpetuating the challenges associated with access to health care services is the vast number of closures of facilities in rural regions across the country. Since 2010, over 113 rural hospitals have closed, and unlike in urban settings, rural hospital closures have been linked to increased mortality rates for time-sensitive conditions. Rural hospitals face unique challenges including low patient volumes, higher rates of uncompensated care, and physician shortages.[8] [9] Physician practices face similar challenges with low patient volumes, and often times, unsustainably low payment rates due to relatively high shares of Medicare and Medicaid patients.

Sustainability is a crucial measure of access in rural settings and can be viewed in terms of physician retention, and the closure rates for hospitals and practices. Once providers open their doors in rural settings, ensuring adequate payment to meet the unique challenges these providers face is crucial to long-term access. Patients in rural settings are more likely to have a disability, more likely to be low-income, and less likely to be in the labor force than patients in non-rural settings.[10] As a result, providers become more reliant on reimbursement from Medicare and Medicaid, and often experience greater care complexity among their patients. For providers with low volumes who often predominantly see Medicare and Medicaid patients, improving payment rates and ensuring payment parity between Medicare and Medicaid can help to ensure that practices are able to keep their doors open.

[8] https://www.americanprogress.org/issues/healthcare/reports/2019/09/09/474001/rural-hospital-closures-reduce-access-emergency-care/
[9] https://www.nber.org/papers/w26182
[10] https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

For hospitals, alternative models for service delivery and payment should be evaluated to ensure access to services in a manner that meets community needs. Hospitals close because they cannot sustain certain services, such as operating an inpatient facility when their patient volume is low. Payment for new models that focus on communities' health care needs may promote hospitals' ability to continue operating.

The AOA and AACOM recommend that HRSA works with CMS to test new health care delivery models for rural areas to evaluate their impact on access to care, hospital closures and openings as a measure of sustainability, and patient outcomes. One of the greatest challenges that rural hospitals face is sustaining a facility prepared to deliver comprehensive inpatient services, when there is insufficient utilization in the community served. Some communities may benefit from the creation of a new hospital designation that allows small rural hospitals, such as critical access hospitals and hospitals with less than 50 beds, to focus on the delivery of comprehensive outpatient and emergency services. An example of this model is the community outpatient hospital model, which would allow small rural hospitals to deliver outpatient services at an enhanced rate to account for volume. These sites would also be required to deliver observation care, comprehensive services that are available in rural health clinics and FQHCs, transportation to other sites for patients requiring inpatient care, and other extended services that support community needs, such as skilled nursing or home health care. Other similar models have also proposed for the inclusion of telehealth services among the required services for the new designation with enhanced payment.

Testing this type of model through a demonstration would help evaluate its impact on availability of providers, patient outcomes, and ability to meet community needs. Ultimately, the sustainability of payment models for hospitals and practices is a key measure of access for rural communities, especially as providers continue to shutter at an increasing rate. Tracking and stopping these closures is essential to ensuring that residents of rural communities can access the care they need.

Impact of the Opioid Epidemic on Communities:
As noted by HRSA in this RFI, we agree that rural communities are often subject to increased health care challenges and certain social risk factors, such as the opioid crisis. COMs and the osteopathic medical community are uniquely positioned to play a prominent role in efforts to tackle the opioid epidemic[11], particularly in the country's rural and underserved communities, where the effects of this crisis are often the greatest. The nation's osteopathic medical schools have consistently demonstrated their commitment to addressing this epidemic. For example, an overwhelming majority of the COMs joined[12] with other medical schools to answer a call for action by the White House Office of National Drug Control Policy and pledged, beginning in the fall of 2016, to require all students to take a form of prescriber education in line with the Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain. In a short time, the COMs have established a variety of unique approaches and partnered with other stakeholders and governing bodies to provide this important level of education.

Additionally, we continue to support pain education at pre-and post-graduate levels for all practitioners whose patient populations face pain-related conditions. Medical students training to become osteopathic physicians receive extra training in the musculoskeletal system, and learn the value of

[11] https://www.aacom.org/reports-programs-initiatives/aacom-initiatives/tackling-the-opioid-epidemic
[12] http://www.aacom.org/news-and-events/news-detail/2016/03/30/033016_opiod-press-release

osteopathic manipulative treatment (OMT) as a non-pharmacological alternative to pain management. When appropriate, OMT can complement, or even replace, drugs or surgery. In this way, OMT brings an important dimension to standard medical care.

4. **How should we measure access to health care services in rural communities?**

As alternative modes of care delivery, such as telemedicine, become more widespread, it is important that patients retain the ability to visit a physician in-person whenever needed. The AOA believes that telemedicine should complement, and not substitute, in-person visits and established physician-patient relationships. As a result, availability of in-person physician and telemedicine services should be measured independently. To ensure adequate access to telemedicine services, it should be paid at rates equal to the rates for when the same service is delivered in person. The AOA supports efforts to monitor telemedicine payment rates and access to services.

Thank you for the opportunity to share feedback on this critical issue. We look forward to partnering with HRSA as it works to develop and implement policies and programs to build a health care system that enables osteopathic physicians to provide the necessary care to meet the needs of our nation's diverse patient populations. If you have any questions or require further information, please contact either of the following individuals:

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Thank you for considering our comments on behalf of the osteopathic medical profession.

Sincerely,

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