AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

January 30, 2025

The Honorable Bill Cassidy
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Catherine Cortez-Masto
520 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
Washington, D.C. 20510

Dear Senators Cassidy, Cortez-Masto, Cornyn, and Bennet:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to express our appreciation for your draft, bipartisan bill that provides much-needed reforms for federal Graduate Medical Education (GME) programs.

The U.S. faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate access to care for patients nationwide. Though the current system excels at educating skilled physicians and physician researchers, the primary care physician shortage prevents the U.S. from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems in other countries.

Evidence indicates that physicians typically practice within 100 miles of their residency program, meaning that the current distribution of trainees in large academic hospitals also leads to physician shortages in medically underserved and rural areas. These shortages result in access barriers and disparities in health outcomes for patients living in rural and underserved communities.

The AAFP encourages Congress to consider ways to reimagine our country's GME system so that it better supports and invests in primary care, including an expansion of training in community-based settings. This will bolster our primary care workforce for the future and allow us to realize the true value of primary care for generations to come, including significant cost savings and improved patient outcomes as we shift toward a system that prioritizes health care, rather than sick care.

Currently, the Teaching Health Center Graduate Medical Education (THCGME) program is one of the only programs that trains residents in a community-based outpatient setting. Although not within Senate Finance Committee's jurisdiction, when asked how best to support the primary care physician workforce, supporting and expanding THCGME is key.

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To date, the THCGME program has trained more than 2,027 primary care physicians and dentists in community-based settings, 61 percent of whom are family physicians.[i] We were extremely disappointed that a bipartisan agreement to include a five-year reauthorization of the THCGME program in the end of the year spending bill was ultimately excluded. Funding uncertainty only serves to undermine the programs, delay the creation of new primary physician training programs, and has also led to some program closures.[ii]

The AAFP will continue to support legislative efforts that would *permanently* authorize the THCGME program. Absent a permanent solution, we urge Congress to, at a minimum, provide a multi-year reauthorization that provides sufficient funding levels to support the true per-resident costs to each program. Supporting THCGME, in conjunction with comprehensive reforms to traditional GME programs, is one of the only ways to ensure a robust primary care workforce and increase access to care in rural and community-based settings.

We are grateful for the collaborative efforts of you and your staff to include patient and physician stakeholder groups throughout the development of this legislative text. Allowing the AAFP and other interested stakeholders to provide comprehensive feedback and participate in roundtable discussions with staff has been a welcome opportunity for us to ensure that any GME program reforms take into account the numerous perspectives that will be integral in expanding access to health care, especially in rural and physician shortage areas.

We provided an in-depth response to the bipartisan Medicare GME working group draft proposal and were encouraged by the inclusion of some of the provisions we supported from that outline in this draft bill. Below we offer our feedback on a section-by-section basis and with answers to the specific questions provided.

## Section 2. Additional Distribution of Medicare GME Residency Positions to Rural Areas and Key Specialties in Shortage

The AAFP is incredibly supportive of the proposal to add 5,000 new additional GME residency slots each year for five years. Although our organization has not identified a specific number of slots required to eliminate the shortage of family physicians over the next decade, this significant increase is welcomed. In lieu of identifying a specific number of slots (both overall and for primary care), the AAFP holds that effective health care systems should have a physician workforce comprised of around 50 percent primary care physicians. We welcome the bill's 25 percent allocation of slots for primary care physicians, and we would encourage an even larger percentage to further mitigate the primary care physician shortage that many areas of the country are already experiencing or will soon be.

While we appreciate the intent to prioritize the distribution of new GME slots to rural and underserved areas, the current bill as drafted still seemingly relies heavily on a Health

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Professional Shortage Area (HPSA) determination. While many residency training programs are located in HPSAs, the physicians training in these programs often do not go on to continue practicing in HPSAs.[iii] In addition, not all HPSAs have residency training programs located in them and therefore basing distribution of residency slots based solely on a HPSA determination is limiting. Ultimately, the current methodology to determine the most effective distribution of GME slots, especially in an effort to increase access to care in rural and underserved communities, does not fully address the issue. By prioritizing those programs that train physicians who practice in HPSAs after completion of their training, GME funding could be used more efficiently to invest in programs with a track record of producing physicians who are more likely to fill existing gaps in health care access.[iv]

We are encouraged by the inclusion of factors such as the ratio of residents per population and GME programs' affiliation with minority serving institutions, but the AAFP believes that additional factors, such as the AAFP's "impact factor," are more effective in ensuring that the majority of new GME slots are really reaching communities of need. This "impact factor" would add to the current methodology for prioritizing GME slots to include the proportion of trainees that ultimately go on to practice in HPSAs.

We were further encouraged by the draft bill language in Section 4 that requires a newly formed GME council to recommend how to measure the retention of physicians in HPSAs and medically underserved communities, and the language in Section 7 noting these key data points would be included in the data that CMS would be required to publicly report. This data should then be incorporated in any updated methodology used to determine the allocation and prioritization of GME slots. This would help ensure that the physicians trained through rural and medically underserved residencies go on to care for underserved populations. The Academy would be happy to work with staff, both in Congress and at CMS, to assist with the development of this methodology given its alignment with the AAFP's "impact factor."

The AAFP also supports an updated definition of rural to align with other CMS-defined criteria (all people and territory in an area with less than 50,000 people, as opposed to 100,000 as proposed in the draft bill) and using that parameter to allocate at least 10 percent of slots to rural hospitals, regardless of their HPSA score.[v] We also applaud the provision within the draft bill that aims to diversify the physician workforce by prioritizing slots at hospitals with an affiliation with a historically black college or minority serving institution. The Academy has long supported policies that aim to diversify the health care workforce. Evidence has shown that students from backgrounds currently underrepresented in medicine are more likely to care for underserved populations in their careers and are more likely to practice primary care.[vi]

The AAFP does support an increase in the cap for GME slots, but our position is that capping the number of slots for all programs at a specific number, this is not the most effective way to increase access to care through these programs. We would encourage reducing the draft bill's slot cap amount of 30 for *all* hospitals, and instead have no caps for programs serving

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rural and underserved communities. Given the data that illustrates the direct correlation between where one trains and where one ultimately decides to practice, removing the cap for GME programs located in rural and underserved areas (as we have defined above) would create more opportunities for physicians to continue practicing in those areas beyond their training.[vii] The AAFP supported the Rural Physician Workforce Production Act, a bill in the previous Congress that would remove the caps on rural hospitals specifically.

We were encouraged to see that the draft bill includes a provision that would establish a per resident amount (PRA) for new direct GME payments. Creating a PRA or payment will support the training of residents at non-hospital sites. However, AAFP policy calls for this PRA or payment to be utilized for *both* direct and indirect GME payments and be determined by evidence-based and transparent methodologies. We would also like this PRA to be applied to existing GME slots as well.

The Academy also suggests that certain infrastructure needs should be considered when determining an appropriate PRA. Given that rural and under-resourced hospitals often face challenges in recruiting faculty and ensuring educational experiences, additional PRA funds should be considered for those facilities. This will help to ensure that these programs will have the same foundational infrastructure to attract and train physicians, especially where they are needed the most.[viii]

## Section 3. Encouraging Hospitals to Train in Rural Areas

The AAFP strongly believes telehealth policies should advance care continuity and the patient-physician relationship. We would support residents permanently being permitted to provide care via telehealth with the same level of supervision from the teaching physician as occurs during their in-person office visits. However, the flexibility to offer telehealth services must be balanced with safety and quality, in addition to promoting and supporting the medical home. We support the language in the draft text that would extend the telehealth flexibility for remote training of residents until January 1, 2026, but would prefer a permanent extension of these flexibilities.

In addition to the telehealth flexibilities included in the draft bill, the AAFP also supports the expansion of allowable services under the Primary Care Exception (PCE). The PCE permits a teaching physician to bill for certain lower and mid-level evaluation and management (E/M) services furnished by residents in certain types of residency training settings, even when the teaching physician is not present with the resident, if certain conditions are met.

The AAFP strongly recommends an expansion of the list of services allowed under the PCE because of the following rationale:

- By allowing all levels of E/M services under the primary care exception, CMS will support primary care workforce development and improve patient continuity of care without compromising patient safety.

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- Including additional preventive services in the PCE services list will increase utilization of high-value services.

The AAFP has submitted extensive comments to CMS highlighting research that supports these changes and also names the specific codes that should be allowed under the PCE. We would appreciate congressional support for these changes and, if necessary, legislative solutions to achieve these changes.

The AAFP also supports the Rural Residency Planning and Development (RRPD) program, which is intended to help address rural GME distribution disparities by supporting the creation and sustainability of rural residency programs. Funding from this program is crucial for training and retaining health care clinicians in rural areas and helps to cover start-up costs, accreditation, faculty development, and recruitment, and it expands the number of trained physicians in rural settings. We have supported legislation to support the codification of this program in statute.

## Section 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

The AAFP supports the language in the draft bill that establishes a Medicare GME policy council that is dedicated to ensuring GME slots are allocated to areas that are expected to experience a physician shortage after 2032, and that this council would include representation of an MD and a DO. We still encourage the inclusion of at least one representative from a THCGME program to provide additional expertise in training primary care physicians in rural and underserved communities.

As stated earlier, we were encouraged that the council would recommend a measure (similar to our "impact factor") that tracks the number of physicians that continue to practice in a rural or medically underserved area after their residency is completed and for how long. The AAFP also believes that any entity created to monitor GME slot distribution to accomplish national workforce goals should be required to establish accountability measures that would be utilized as a condition for sustained GME payments. Further, we believe the council should serve not just as an advisory body but should have statutory authority to reallocate slots based on the confluence of factors included in the draft bill.

Our recommendations could also be achieved by expanding the authority of the Council on Graduate Medical Education (COGME) and mandating that COGME tracks data regarding whether physicians continue to practice in rural and underserved areas after they complete their residency programs. The AAFP is comfortable with either option as long as the authority to make direct decisions on distribution and the data collection outlined in the draft bill are explicitly provided.

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## Section 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

The AAFP has long supported eliminating or extending the time window to establish the PRA or residency full-time equivalent (FTE) cap for GME programs in HPSAs. Extending the time and window for GME programs that can illustrate the "impact factor" would further address primary care shortages in rural and underserved areas. Therefore, the language in the draft bill should be amended to include all GME programs located in HPSAs, not just those determined to be eligible under the Consolidated Appropriations Act of 2021. Further, as stated previously, certain infrastructure needs and additional funding sources for establishing new programs should be considered.

## Section 6. Improvements to the Distribution of Resident Slots under the Medicare Program After a Hospital Closes

As stated in our response to the bipartisan Medicare GME working group's draft outline, the AAFP supports the proposed changes in this section and are glad to see them included in the draft bill.

## Section 7. Improving GME Data Collection and Transparency

The Academy strongly applauds Section 7 of the draft bill. The AAFP has supported legislative efforts in the past regarding the increased need for transparency and data collection within GME programs. As stated in our response to the Medicare GME working group's draft proposal, having this data will help address our nation's current maldistribution of physicians and allow us to target the allocation of GME slots to hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

In addition to these important data collection reforms, we still feel that the draft bill should include stricter reporting requirements related to the closure of a teaching hospital or dissolution of a GME slot or program. These closures and program terminations are incredibly disruptive to the communities they serve and to the residents that must find a new GME slot to complete their residency program. Any reporting that would give residents advanced notice or illustrate the threat of an impending closure would allow greater time for them to find a GME slot at another facility, or it could be used to explore the need for additional funding opportunities to ensure the continuation of a GME program and prevent the closure of the related facility.

We also support the provisions in the bill that recognize the existing data sets that can assist CMS in collecting the new data outlined in the draft text. Using existing data sets will help minimize the administrative burden on CMS and the GME program administrators.

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Thank you for the opportunity to provide this feedback and for championing long-overdue reforms to our nation's GME system. We look forward to partnering with you on these efforts to best train family physicians and care for the patients they serve. If you have any questions, please contact Megan Mortimer, Manager of Legislative Affairs at mmortimer@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

Steve Furr, MD, FAAFP
American Academy of Family Physicians, Board Chair

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[i] Teaching Health Center Graduate Medical Education (THCGME): Expanding the Primary Care Workforce | Bureau of Health Workforce
[ii] Funding Instability Plagues Program That Brings Docs to Underserved Areas - KFF Health News
[iii] Joint AAFP CAFM Letter to CMS on GME Final Rule - February 24, 2022
[iv] Joint AAFP CAFM Letter to CMS on GME Final Rule - February 24, 2022
[v] How We Define Rural | HRSA
[vi] Walker, Kara Odom et al. "The association among specialty, race, ethnicity, and practice location among California physicians in diverse specialties." Journal of the National Medical Association vol. 104,1-2 (2012): 46-52. doi:10.1016/s0027-9684(15)30126-7
[vii] The Distribution of Additional Residency Slots to Rural and Underserved Areas | Health Disparities | JAMA | JAMA Network
[viii] Graduate Medical Education Financing Policy | AAFP

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