

May 18, 2022

Paul B. Greenberg, MD
Deputy Chief
Office of Academic Affiliations (14AA)
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, D.C. 20420

RE: RIN 2900-AR01 – VA Pilot Program on Graduate Medical Education and Residency

Dear Dr. Greenberg,

On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, and the North American Primary Care Research Group, as well as the American Academy of Family Physicians (AAFP) we write in response to the proposed rule to implement a Department of Veterans Affairs (VA) pilot program on graduate medical education (GME) and residency, as required by the Maintaining Internal Systems and Strengthening Integrated Outside Network (MISSION) Act of 2018.

We have supported the expansion of GME provisions in both the Veterans Access, Choice, and Accountability Act (VACAA) and MISSION Acts. Our strong support is based on a belief that the VA must do more to increase training in rural and other underserved areas, and consequently to build a VA physician workforce that can provide much better access to veterans than the current system delivers. A recent VA report, projected that by 2033, there will be an estimated nationwide shortage of between 21,400 and 55,200 primary care physicians.¹ Additionally, it was identified that 57 VA facilities had severe primary care shortages.²

We have five areas of concern in the proposed rule to implement the VA's GME and residency pilot program for which we are making recommendations in our comments: 1) veterans access to comprehensive, timely care in rural communities – areas that frequently have few or no federal training sites; 2) the VA definition of "Covered Facilities"; 3) the process the VA intends to use for soliciting interest; 4) the potential weighting of factors in the selection process; and 5) the need for evaluation of the pilot program. We make these recommendations with a view toward encouraging the VA to expand beyond its traditional methods and processes and use this pilot program to innovate as much as possible.

Rural Access to Care

Nearly 33 percent of VA's enrollee population live in rural or highly rural areas compared to 19 percent of the general population, emphasizing the need for innovative, sustainable rural health solutions nationwide. Even with the addition of 1,500 full-time equivalent (FTEs) residency positions through the Veterans Access, Choice, & Accountability Act, rural FTEs made up only 5.9 percent of new positions.³ The issue of rural access has been further compounded with the closure of 136 rural community hospitals between 2010 and 2021.⁴ Veterans living in rural areas



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have difficulty accessing health services for reasons similar to other rural residents. Some rural veterans face poverty, homelessness, and substance use disorder, which can exacerbate their health issues. In addition, some veterans are unaware of the benefits, services, and facilities available to them through the VA.

The VA has made some efforts through the passage of the MISSION Act of 2018 to address health access issues affecting rural veterans with programs such as the Veteran Community Care Program, which provides an option for rural veterans meeting certain criteria to receive care from a community clinician. We also know most physicians are trained at large academic medical centers in urban areas, and evidence indicates physicians typically practice within 100 miles of their residency program.⁵ As a result, the current distribution of trainees leads to physician shortages in medically underserved and rural areas. **We urge the Secretary to expand the pilot in ways that would target support for the training of more physicians in rural communities with a focus on producing physicians that will ultimately practice in these areas.**

Additionally, we want to raise a general concern about sustainability of the pilot programs. After the pilot program ends, covering just salary and benefits would be a significant financial barrier for stability and expansion, particularly for new and small residency programs. **We urge the Secretary to consider ways the VA can provide long-term support – particularly for small and new residency programs – to ensure veterans have continued access to care.**

Section 17.245—Covered Facilities

Section 17.245 would list the covered facilities in which residents may be placed under the pilot program as those included in the statute: Covered facilities would include any of the following:

- A VA health care facility;
- A health care facility operated by an Indian tribe or tribal organization;
- A health care facility operated by the Indian Health Service;
- A federally-qualified health center;
- A health care facility operated by the Department of Defense; or
- Other health care facilities deemed appropriate by VA.

It is this last area, “other health care facilities deemed appropriate by the VA” for which we make recommendations. We would like to see the regulation identify two specific options for inclusion under this criterion. **First, we recommend Rural Health Clinics be included as covered facilities.** The Rural Health Clinic (RHC) program⁶ is intended to increase access to primary care services for patients in rural communities. RHCs can be public, nonprofit, or for-profit healthcare facilities. To receive certification, they must be located in rural, underserved areas. They are required to use a team approach of physicians working with non-physician providers such as nurse practitioners (NP), physician assistants (PA), and certified nurse midwives (CNM) to provide services. RHCs are required to provide outpatient primary care services and basic laboratory services. However, RHCs may or may not serve as training sites for residency programs, and like the VA’s Community Oriented Outpatient Clinics (CBOCs), most are not set up for participation in training, lacking faculty and other training infrastructure. Including Rural Health Clinics as covered facilities will allow them to be eligible for funding to build capacity to provide training.

Second, we recommend that the VA include rural training sites, which include family medicine or other specialty training programs, to be included under this criterion. Currently most rural training sites have been in the specialty of family medicine, but with the

new changes to rural track programs included in the Consolidated Appropriations Act of 2021, the VA can expect other specialties to expand training in rural areas.

The VA is charged with education of a clinical workforce for the VA *and for the nation*, as well as improving access to care for our nation's Veterans. The key reason for expanding training in non-traditional entities is that disciplines such as family medicine provide the majority of health and primary care access in rural areas. The pilot program is an opportunity to help produce physicians who can provide comprehensive primary care to veterans. We believe that these types of community-based training would not only be viable routes for the VA to take in this pilot, but would also improve access to timely and comprehensive care for veterans in rural areas and produce the physicians that will care for these communities in the future. **Our proposal would leverage family medicine and other community-based training programs to help the VA accomplish its goals, especially in rural areas.**

Section 17.246 – Consideration Factors for Placement of Residents

The proposed rule lists the factors (below), that it will consider for placement of residents but stipulates that it is not weighting the factors in the regulatory text, although it may assign levels of relative importance as part of its selection process. The determination of the relative importance of each of the factors should not be done out of the public eye, or without public comment on each of their relative values. For example, we would recommend prioritizing “whether a specialty of a provider is included in the most recent staffing shortage determination,” the consideration of whether the facility is in a rural or remote area, and proximity to a VA health care facility. **We recommend the Secretary revise this position and include any weighting or priority within the regulation and allow for comment on the relative weights of the factors.**

The VA proposes to consider the following factors in the placement of residents:

- The ratio of veterans to VA providers for a standardized geographic area surrounding a covered facility (i.e., the surrounding county), including a separate ratio for general practitioners and specialists. A higher ratio of veterans to VA providers indicates a higher need in an area.
- The range of clinical specialties of VA and non-VA providers for a standardized geographic area surrounding a covered facility, where the presence of fewer clinical specialties indicates a higher need for health care providers in an area.
- Whether the specialty of a provider is included in the most recent staffing shortage determination by VA.
- Whether the covered facility is in the local community of a VA facility that has been designated by VA as an underserved facility pursuant to criteria developed under the MISSION Act.
- Whether the covered facility is located in a community that is designated by the Secretary of Health and Human Services as a health professional shortage.
- Whether the covered facility is in a rural or remote area as identified by the U.S. Census Bureau and the Economic Research Service within the U.S. Department of Agriculture, respectively.
- Other criteria as VA considers important, including, but not limited to, (i) proximity of a non-VA covered facility to a VA health care facility, such that residents placed in non-VA covered facilities may also receive training in VA health care facilities, and (ii) programmatic considerations related to establishing or maintaining a sustainable residency program, such as: whether the stated objectives of a residency program align with VA's workforce needs; the likely or known available educational infrastructure of a

new residency program or existing residency program (including the ability to attract and retain qualified teaching faculty); and the ability of the residency program to remain financially sustainable after the cessation of funding that VA may furnish under the pilot program.

We recommend the VA change the first factor. As written, it would include a ratio of veterans to VA providers and include a separate ratio for “general practitioners and specialists.” **We recommend that the term “general practitioners” be changed to “primary care physicians” and the phrase be changed to “primary care physicians and other specialists.” We would go further and ask that the VA include ratios of each primary care specialty with the population of veterans.** Internal medicine focuses exclusively on adult medicine, while family medicine typically sees all the members of a family - children as well as adults. Family medicine also provides the full spectrum of women’s health care that women veterans need across the lifespan. Given that the gender and age of veterans is becoming increasingly more varied, and include a wider distribution of ages, respectively, there would also be a need for family physicians, not just internal medicine physicians to take care of the veteran population. Family physicians are trained to provide comprehensive, longitudinal primary care services for patients across the lifespan, including chronic disease management, reproductive health care, maternity care, treatment of acute illnesses, and preventive care. In short, family physicians are well positioned and trained to provide comprehensive care to our nation’s veterans and the supply of family physicians who can provide this comprehensive care should be considered when placing residents in training opportunities.

Section 17.247 – Determination Process for Placement of Residents

We disagree with the policy outlined in the proposed rule that the VA would not solicit the interest of covered facilities to participate in the pilot program through a public request for proposal. We further object to the use of current VA facilities as the entity that would apply for these positions and submit responses to the RFP. This process was also used for filling the VACAA positions and we found it to be detrimental to the goal of creating physician training that would be supportive of all specialties in shortage.

In rural areas, where one might suspect that CBOC facilities might be the ones to help facilitate the application process, we found anecdotally that CBOC medical staff are often unfamiliar with and do not frequently participate in teaching in training programs and so many did not have interest in supporting these applications. Within the VA in general, there is a lack of familiarity with family medicine and how family medicine training differs from that of other primary care programs, such as internal medicine. Family physicians are uniquely trained to provide comprehensive primary care across the lifespan, as well as reproductive health and maternity care. When approached during the VACAA position process many VA Administrators expressed a view that their internal medicine relationships address primary care needs – and thus do not see the need to increase training opportunities in family medicine. Effectively, by the VA continuing to use current VA facilities as the applicant entity and rejecting a public approach for applying for these residency positions, it is continuing a process that has been ineffective and creates an additional hurdle for training entities of convincing VA institutions of the need for family medicine training positions. On the other hand, many of the covered entities regularly work with family medicine trainees and are well positioned to quantify and articulate how additional training opportunities could support Veterans’ access to comprehensive primary care within their communities. **Therefore, we recommend that the VA solicit request for resident positions in this pilot program through a public solicitation process (i.e., a public request for proposal).**

Evaluation of the Pilot Program

We are concerned that there is no mention of evaluation of the pilot in the proposed rule. The only evaluation relates to how well the applications match up with the factors included under Section 17.246. As with any pilot project, the concept is to test an idea or process to see if it can/should be scaled up. It attempts to answer the question as to whether the pilot has the potential to deliver a satisfactory return on investment. We would like to see the following questions included in the final rule criteria for an evaluation of the pilot: 1) was it successful in accomplishing a predetermined goal; 2) does it provide increased access for veterans to comprehensive primary care and needed specialty care; and 3) are the physicians trained under this pilot continuing to provide access to veterans after training, and in areas of greatest need? **We recommend these, and other, questions be included in an explicit evaluation of the pilot program and should be enumerated in the final regulation.**

Thank you for your consideration of our comments. We look forward to continuing to work with the VA to address the veterans' access issues through training and to strengthen the production of primary care physicians who can serve veterans across the country. Should you have any questions, please contact Meredith Yinger, the AAFP's Manager of Regulatory Affairs, at myinger@aaafp.org and Hope Wittenberg, CAFM's Director of Government Relations, at hwittenberg@stfm.org.

Sincerely,



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¹ Dept. of Veterans Affairs. (2022, March). *VA recommendations to the asset and infrastructure review commission*. Dept. of Veterans Affairs. Retrieved March 22, 2022, from <https://www.va.gov/AIRCOMMISSIONREPORT/docs/VA-Report-to-AIR-Commission-Volume-I.pdf>

² Dept. of Veterans Affairs. (2021, September). *VHA - OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*. Dept. of Veterans Affairs . Retrieved March 22, 2022, from <https://www.oversight.gov/sites/default/files/oig-reports/VA/VAOIG-21-00278-23.pdf>

³ https://www.va.gov/OAA/docs/OAA_Stats_AY_2020_2021_FINAL.pdf

⁴ Dept. of Veterans Affairs. (2022, March). *VA recommendations to the asset and infrastructure review commission*. Dept. of Veterans Affairs. Retrieved March 22, 2022, from <https://www.va.gov/AIRCOMMISSIONREPORT/docs/VA-Report-to-AIR-Commission-Volume-I.pdf>

⁵ Fagan BE, Finnegan SC, Bazemore AW, Gibbons CB, Petterson SM. Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training - Graham Center Policy One-Pagers - American Family Physician.

⁶ <https://www.ruralhealthinfo.org/topics/rural-health-clinics> (accessed Mar 23, 2022)