**To:** Biden Transition Team

**From:** Council of Academic Family Medicine

**Re:** Primary Care Priorities related to workforce and research

**Date:** December 22, 2020

**Introduction:**

The Council of Academic Family Medicine (CAFM) is a coalition of organizations collectively representing family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, primary care research scientists, and others involved in family medicine education. We write to request the inclusion of our priorities by the Biden transition team as you develop your health agenda. We are strongly concerned about equitable health access and care, including addressing the concerns of our most vulnerable populations and addressing health care disparities. We expect, given the President-elect’s public remarks regarding his agenda, for these key broad concerns to already be on his agenda. Therefore, our comments today are tailored to include the issues we are most expert and involved in, and for which we advocate that may not be included in the larger public debate – specific solutions in the domain of academic family and primary care medicine and research that we believe will help address health care access and address disparities. In each of these areas there are policy lessons to be learned from the COVID-19 pandemic.

**Executive Summary:**

* **General Medicare Graduate Medical Education (GME) Reform.** We recommend system reforms including replacing Indirect GME and Direct GME payments with a per resident payment, permanently expanding and extending the primary care exception, and reimbursing adequately for phone visits.
* **Rural GME Reform.** We recommend specific GME reforms to address the maldistribution in GME payments in rural vs urban areas such as: removing limitations on growth of residency slots for physician training in rural areas; instituting a per resident payment that satisfactorily covers the costs of rural training; modernizing the definition of rural areas used by CMS for GME purposes; and revising the regulation the Center for Medicare and Medicaid Services (CMS) uses to implement the establishment of caps and payment amounts for brief training rotations in non-teaching hospitals.
* **Permanently Fund and Reauthorize the Teaching Health Center Graduate Medical Education (THCGME) Program:** We recommend that Congress permanently fund and reauthorize the THCGME program and provide a technical fix to include THC residents under the Primary Care Exception:
* **Include Rural Hospitals under the COVID Provider Relief Fund.** We recommend that the Department of Health and Human Services (HHS) create a specific funding stream for rural hospitals that maintain physician training programs for three years.
* **Physician Payment and Delivery Reform Models.** We recommend that CMS incorporate teaching practices in new and ongoing payment and delivery reform models.
* **Increase Funding for Title VII of the Public Health Service Act.** We recommend that Congress increase funding for the Primary Care Training and Enhancement Program under Title VII. We also recommend increased Title VII funding for COVID purposes.
* **Increase AHRQ Funding and Fund the Center for Primary Care Research at AHRQ.** Congress should fund the authorized Center for Primary Care Research at the Agency for Healthcare Research and Quality (AHRQ) and also increase AHRQ COVID funding.

**Workforce:**

There are several key programs within the federal government that address the development of a sufficient, well prepared physician workforce but fail to address the specialty or geographic maldistribution of the physician workforce. Below are specific solutions to these issues.

1. **Medicare Graduate Medical Education (GME)** is a key factor in the production of the nation’s physician workforce – influencing not only the number of physicians but the type of specialty and where they practice. Yet the funding and distribution of GME is without strategic direction and often fails to meet the nation’s physician workforce needs. Reform is needed overall, and in specific areas.
2. **General Medicare GME Reform**: Effective health care systems have a physician workforce comprised of roughly 50% primary care and 50% subspecialty. However, the current U.S. physician workforce is 33% primary care. Overall, the nation has an inadequate supply of family physicians, general internists, general pediatricians, general surgeons, and psychiatrists, relative to the number of other medical specialists. To address these concerns, we recommend the following:
3. **Legislation to Modernize GME Financing by Replacing Indirect Medical Education (IME)/Direct Graduate Medical Education (DGME) payments with a per-resident payment (PRP.)** Modernizing GME payment methodology is necessary to make strategic investments that support a more equitable, rational physician workforce and support the development of training at non-hospital sites. This is consistent with the Institute of Medicine’s (IOM) 2014 recommendation to replace rigid statutory formulas that were developed in an era when hospitals were the central site for physician training.[[1]](#endnote-1) We advocate for combining IME and DGME financing streams into a single payment, with funds distributed as a national, evidence based, transparent, and predictable PRP. A current model is the Teaching Health Center GME program and we cite an additional example of this below under our rural GME proposal.
4. **Fund a National Health Care Workforce Commission**. Current Medicare GME funding is not disseminated strategically to address comprehensive workforce needs. The Affordable Care Act established but did not fund a national health workforce commission (42 U.S. Code § 294q.) We support a robust planning effort that would direct public workforce investments toward producing a health care workforce that addresses population health needs, (including geographic, physician specialty, other health care disciplines, diversity) as well as health care disparities and health equity.
5. **Primary Care Exception Policies.** CMS implemented the primary care exception (§ 415.174 Exception: Evaluation and management services furnished in certain centers) in 1996. The exception allows, under certain restricted circumstances, the “teaching physician” to supervise a resident (a training physician) *immediately after* a patient visit, rather than the typical mandate that the supervision occur during the patient encounter. The purpose is to allow the trainee to develop a continuity relationship with the patient and to be viewed by the patient as their physician, while still ensuring supervision by, and payment of, the teaching physician. There are a limited number of lower-level, moderately complex codes that are included under this exception. This has been a very successful part of the training of family medicine residents.

Even before the onset of the Public Health Emergency (PHE) we supported an expansion of permanent codes under the primary care exception. Of key importance to us are the codes listed below, which should be permanently extended.

**Make permanent the inclusion of 99204 and 99214 codes under the exception:**

As part of our comments on the CY2019 fee schedule proposed rule, we recommended the inclusion of many of these codes under the primary care exception.

“While this may have made sense at the time of the establishment of the exception, in 1995, as the 99204s and 99214s were considered complex visits often involving patients with acute or unstable chronic conditions requiring the teaching physician to personally examine and assess the patient in order to assure a high standard of care, this isn’t the case now. Currently, within the Medicare population it is not unusual to find patients with three or more chronic conditions presenting for new and follow-up visits that require a level of time and decision-making consistent with a level 4 code for management of multiple chronic conditions, but do not involve a level of diagnostic complexity that is beyond the resident physician’s ability to provide quality care with indirect supervision.

In addition, in recent years, medical training has moved further toward competency-based assessment and rigorous standards have been put in place regarding supervision. The ACGME has moved toward competency-based education by the development of the common program requirements (<https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements> )

With these internal processes in place, we believe it is both safe and advantageous for CMS to include the 99204 and 99214 E&M codes in the primary care exception.

**Phone visits:** We ask that CMS make phone visit codes permanent under the primary care exception and funded equivalent to E&M visit codes. Work performed by residents, and precepted by teaching physicians have traditionally not been billable under time-based codes. This changed as part of the PHE and we support the permanent continuation of this change. We believe that residents should be able to provide those services by phone and be supervised as they normally would be under the primary care exception. If a Medicare patient does NOT have video capability, and either is not safe to come to office, or has difficulty physically getting there, family medicine residency practices need to be able to perform a phone visit using 99441-3. Logistically, it is not practical to have the attending physician work force spend direct time on the phone with the patient in addition to the resident, especially for the visits incorporated under the primary care exception. Programs can still comply with the 1:4 ratio (preceptor/resident) requirements of the exception, where teaching physicians will still be immediately available for supervision, and precept every case -- the only difference is lack of video.

1. **Rural Medicare GME Reform:** A 2013 Academic Medicine article reports that only 4.8% of all graduates of 759 sponsoring institutions practiced in rural areas and 198 of those 759 institutions produced no rural physicians. This percentage compares unfavorably to the 19.3% of the population classified as rural by the 2010 census. Moreover, the patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians in urban areas. Similarly, the number of total physicians per 100,000 people in rural versus urban areas is 13.1 compared to 31.2.[[2]](#endnote-2)

There are many causes of this maldistribution, but the statutes and regulations within Medicare GME play a large part. S. 289, introduced in the 116th Congress by Senators Gardner (R-CO) and Tester (D-MT), would address these issues as follows:

1. Limitations on growth of residency slots for physician training in rural areas. When Congress set in place the limitations on Medicare payment for residency training slots, it stated in several places in the statute and the report language that special consideration should be given to rural areas. However, CMS has a narrow interpretation of the statute. For this reason, we support the removal of caps on rural residency training slots, including those related to urban hospitals supporting rural training through rural training tracks.
2. Institute a per resident payment amount that satisfactorily covers the costs of rural training. The costs or rural training are inadequately accounted for in the traditional Medicare GME payment formulas. Such payments should be reimbursed for training in all settings – including critical access hospitals and sole community hospitals.
3. Modernize the definition of rural areas used by CMS for GME purposes. An area should be considered rural for GME purposes if it fits any of these three categories: traditional Metropolitan Statistical Areas (MSA’s), Rural-Urban Commuting Area (RUCA) codes (four and above would be considered rural), and training sites within 10 miles of a Sole Community Hospital (SCH) including training at a SCH.
4. Revise the regulation CMS uses to implement the establishment of caps and inappropriately low payment limits for brief training rotations in non-teaching hospitals. Hospitals that accepted small numbers of medical residents for very brief rotations from new teaching programs established after the 1996 base year unknowingly triggered a resident cap, even if they did not seek Medicare funding for those rotations. Hospitals that accepted any rotations from any teaching program inadvertently triggered a permanent cost limit. CMS policy in this area was unannounced and unclear. This policy has triggered multi-faceted problems in rural training programs across the country. These policies had a chilling effect on rural hospitals who previously were desired locations for experiences in rural training. HR 1358, introduced by Reps. Kind (D-WI) and Gallagher (R-WI), provides some relief for this issue, while S. 280 addresses it fully for rural areas.
5. **Permanently Fund the Teaching Health Center Graduate Medical Education (THCGME) Program:**

Included as part of the Affordable Care Act, teaching health centers (THC) have played a vital role in training the next generation of primary care physicians, with residents handling an estimated one million patient visits annually in both rural and urban underserved communities. Since 2011, the THCGME program has supported the training of over 1,148 new primary care physicians and dentists. Cumulative follow-up data indicate that 65 percent of physicians and dentists are currently practicing in a primary care setting and approximately 55 percent are currently practicing in a MUC and/or rural setting. (HRSA Program Highlights: <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/funding/teaching-med-edu-2019.pdf> ).

1. **Permanent Authorization.** Unfortunately, the program suffers from instability. Multiple times, Congress has failed to reauthorize the program in a timely manner, and there has only been one reauthorization that has allowed for some growth in the program. Without long-term stability, it has been and will continue to be extraordinarily difficult for the more than 50 THCs across the country to recruit and operate effectively. The program should be funded permanently, with entitlement funding. The program parameters (which are different than Medicare GME) should be retained and it can continue to be managed out of the Health Resources and Services Administration (HRSA), but the funding should be similar to Medicare GME – if a program qualifies, it should be funded.
2. **Technical Fix to Include Teaching Health Center Residents Under the Primary Care Exception:** A technical problem exists regarding allowing payments under the Teaching Physician primary care exception to be made for residents training in THCs. These regulations allow for independent practice, by residents and subsequent billing for certain non-complex codes in ambulatory practice settings. Because the regulations were written in 1995, before THCs came into existence, they are limited to situations where residents are funded under Medicare GME, while THC residents are funded through HRSA. Residents whose training is paid for by HRSA, rather than CMS/Medicare, should not be treated differently in terms of supervision if they fit the other requirements of the primary care exception. CMS should apply the Teaching Physician Primary Care Exception rules for payments for services furnished by residents in patient care activities in determining payments made under Section 340H of the Public Health Service Act in addition to those furnished by residents under Medicare GME. (See §415.174 (a)(1)).
3. **Rural Hospitals Supporting Physician Training Programs:**

We are concerned over the impact of rural hospital closures, both in terms of their communities’ access to health care, but also in terms of their ability to maintain physician training programs. As noted above, most rural hospitals do not receive adequate funding from Medicare GME to pay for the costs of training. Given the economics of rural residency training, we are concerned that as rural hospitals face financial ruin, a residency program is convenient ballast – easily jettisoned to help the financial bottom line. Even hospitals that do not close, may, in the short term, choose to decrease or eliminate their residency due to its added costs. Bipartisan and bicameral letters were sent to the Secretary of HHS to support[[3]](#endnote-3) Provider Relief Fund monies for rural hospitals that support physician training programs and maintain them for three years. The proposed payment is not a substitute GME payment, but rather is an incentive payment to a rural hospital connected to a commitment to maintaining the current training program(s) within the difficult COVID-19 environment. Under our proposal, a rural hospital which serves as the primary location of training of greater than 50% of residents’ time, would receive the bonus payments upon agreeing to maintain its training program(s) for the next three academic years. Our proposal would have a cost of approximately $88.35 million, supporting 90 rural hospitals across 39 states.

1. **Physician Payment and Delivery Reform:**

As CMS and its Center for Medicare and Medicaid Innovation move forward with payment and delivery reform models, we feel it is critical that teaching practices, typically excluded, are incorporated into these models. Training of the primary care pipeline is done in the community -- in individual practices as well as academic settings. The difficulty in finding adequate, advanced practice model practices for students and/or primary care residents as well as other health professions to train in is a key concern for growing the primary care workforce. Small, independent primary care practices face losing money by bringing students and/or residents into their practices, and larger practices bought up by health systems are frequently not allowed to bring trainees into those practices. These issues have only been exacerbated by COVID-19’s impact on the financial health of primary care practices. Identifying models that work well for teaching - students, residents, and other primary care health professions will be key to the development of the primary care workforce. We need to ensure the pipeline of the primary care physician workforce and payment models need to test/model real world teaching practices, particularly in rural and urban underserved areas.

1. **Title VII of the Public Health Service Act – Primary Care Training and Enhancement Program**

The Primary Care Training and Enhancement Program (Title VII, Section 747 of the Public Health Service Act) has a long history of funding training of primary care physicians. As experimentation with new or different models of care continues, departments of family medicine and family medicine residency programs will need to rely further on Title VII, Section 747, grants to help develop curricula and research training methods for transforming practice delivery. The Advisory Committee on Training in Primary Care Medicine and Dentistry December 2014 report states that “[r]esources currently available through Title VII, Part C, sections 747 and 748 have decreased significantly over the past 10 years and are currently inadequate to support the [needed] system changes.” To address some of these challenges, the Advisory Committee recommended that Congress increase funding levels for training under the primary care training health professions program to meet the pent-up demand caused by reduced and stagnant funding levels. However, funding for this program has mainly remained stagnant.

This need has been exacerbated by the impacts of COVID-19 and its implications for producing a physician workforce that address issues such as health equity and social determinants of health. Future training needs include training in new clinical environments and curriculum develop around telehealth, practice transformation, inter-professional teams, and public health competencies.

1. **COVID-19 specific recommendations**: Congress should appropriate an additional $125 million in new funding for Title VII, Section 747 (Primary Care Training and Enhancement) for COVID-19 specific issues. This funding should be directed to both residencies and departments to identify best practices to increase primary care’s ability to improve inpatient care capacity. Localities are currently using primary care providers to support over-burdened inpatient settings and new inpatient settings across the U.S.
2. Additional Title VII, Section 747 funding could be used to identify appropriate training needs to train current students and residents and retrain primary care providers to support our nation’s care needs:
3. Develop curricula that meets the needs of the pandemic, and for the future. Curriculum is needed in best practices for remote supervision of residents; caring for stable chronic disease patients and select acute care needs over the phone and virtually through telehealth; training for crisis management; and conducting e-consults with specialists in both the inpatient and outpatient setting.

**Investing in Primary Care Research:**

1. In the AHRQ 1999 reauthorization, Congress authorized the AHRQ’s Center for Primary Care Research to “serve as the principal source of funding for primary care practice research in the Department of Health and Human Services.” However, the Center has no funding. In 2018, Congress authorized an independent assessment of federally funded health services research (HSR) and primary care research (PCR). Among its findings was that:
	1. Fifty-seven percent of AHRQ projects were considered HSR and 13% were classified as PCR. Of 86,000 projects funded by NIH, 8% were considered HSR and less than 1% PCR. When totaled 1% were primary care research though primary care is the place where most people get most of their care[[4]](#endnote-4),[[5]](#endnote-5)
	2. PCR has been consistently underfunded over the years.
2. The Rand study recommended, and we support:
	1. Targeted funding for a hub for federal PCR is needed.
3. A funded entity (such as AHRQ’s Center for Primary Care Research) should address core primary care research needs and coordinate federal PCR efforts.
4. **COVID-19 specific recommendations**:

The COVID-19 Public Health Emergency (PHE) has made visible many of the cracks in our health care system and our primary care infrastructure is in crisis. AHRQ is uniquely positioned to find answers to these questions with a proven track record of delivering timely results that identify what works – and what does not – in health care delivery. In this regard, we support the following recommendations:

1. Funding a PCR Center to assist with COVID related research needs.
2. Additional AHRQ funding is needed in the primary care/ambulatory COVID-19 space to address the following research needs and gaps:
* Evaluations and research related to primary care clinical research and the health care system’s response to the COVID-19 virus particularly in the ambulatory setting that includes best practices related to incorporating medical students and residents.
* System-wide research to evaluate the impact of the pandemic on primary care practice and training as well as best practices to keep the chronically ill out of emergency departments.
* Research into appropriate ambulatory care for patients (and their family members) with COVID-19.
* Deferred primary care: Research is needed to determine: what kind of patients are still waiting for care; what will a surge of deferred care look like; and lastly, how have changes impacted utilization and practice patterns of primary care practices?
* The physical and emotional burden of the current crisis on providers, in patients and the community.
* Primary care practice during the crisis: Research could address issues such as appropriate ways to practice at the top of the license during the pandemic, and afterwards.
* Telehealth best practices for primary care physicians and residents with a focus on telehealth with specific attention to how to reach rural and underserved areas.

**Conclusion:**

The primary care infrastructure in our nation faces difficult challenges, many of which existed prior to COVID-19, including troubling health disparities; pandemic-related disruptions to research and practice, and long-term avoidance of needed remedies to our workforce dilemmas. We urge President-elect Biden to address these challenges, both internally with Administrative relief where possible, and working with Congress to provide needed legislative relief and funding.

Thank you for the opportunity to provide our views to the transition team. If you have further questions, please contact Hope Wittenberg Director, Government Relations at 202-986-3309 or hwittenberg@stfm.org



1. Institute of Medicine. 2014. *Graduate Medical Education That Meets the Nation's Health Needs*. Washington, DC: The National Academies Press. https://doi.org/10.17226/18754 [↑](#endnote-ref-1)
2. <https://www.ruralhealthweb.org/about-nrha/about-rural-health-care>. Retrieved Mar 16, 2018 [↑](#endnote-ref-2)
3. <https://www.stfm.org/media/3131/20200717-senate-final_rural-provider-training-programs.pdf>; <https://www.stfm.org/media/3129/111320-final-with-names-wenstrup-sewell-rural-residency-provider-relief-fund-letter.pdf> [↑](#endnote-ref-3)
4. #  Green LA, Fryer GE, Yawn BP, Lanier D, Dovey SM. The Ecology of Medical Care Revisited. N Engl J Med 2001; 344:DOI: 10.1056/NEJM200106283442611.

 [↑](#endnote-ref-4)
5. Petterson S, McNellis R, Klink K, Meyers D, Bazemore A. The State of Primary Care in the United States: A Chartbook of Facts and Statistics. January 2018. [↑](#endnote-ref-5)