CAFM Council of Academic Family Medicine

Society of Teachers of Family Medicine
Association of Departments of Family Medicine
Association of Family Medicine Residency Directors
North American Primary Care Research Group

June 4, 2021

The Honorable Jon Tester
311 Hart Senate Office Building
US Senate
Washington, DC 20510

The Honorable John Barrasso
307 Dirksen Senate Office Bldg.
US Senate
Washington, DC 20510

Dear Senators Tester and Barrasso:

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, the North American Primary Care Research Group, we thank you for your leadership in introducing "The Rural Physician Workforce Production Act of 2021." This legislation is a strong step in addressing the geographic maldistribution of physicians. It targets growth in graduate medical education positions toward a policy goal the nation needs – providing an avenue to increase production of physicians who train and will work in rural areas of the country.

The geographic maldistribution of primary care physicians is one of our nation's most intractable problems affecting access to care. Rural areas particularly lack access to primary care physicians and other shortage specialties compared to urban and suburban areas. The current COVID-19 pandemic has exacerbated the situation and shown light on the increasing need in rural areas for an adequate physician workforce and health care infrastructure. One of the most promising solutions to this problem is increasing physician training in rural areas. Congress has made some progress in this area (e.g., the Teaching Health Center Graduate Medical Education (GME) program), but vastly more is needed to support rural training.

Medicare remains the dominant driver of GME policy in the United States, as it accounts for two-thirds of public funding for residency training (roughly $10 billion out of some $15 billion altogether per year). Medicare is the only stable national source of GME funding, in comparison to other grant funding such as HRSA-run programs and Medicaid GME funding. Rural hospitals operate on narrow margins and cannot commit to ongoing residency training costs without a predictable source of funding. The last major revision to Medicare GME policies took place over 20 years ago, in the Balanced Budget Act of 1997 (BBA). The BBA placed upper limitations (known as "caps") on institutions sponsoring residency training for the first time. Although the BBA and subsequent legislation also provided incentives for rural training, the law and its implementation by the Centers for Medicare & Medicaid Services (CMS) has discouraged maximum growth in rural training.

The Government Accountability Office (GAO) recently released a study[i] on physician workforce, stating that "use of federal efforts intended to increase GME training in rural areas was often limited and challenging. CMS reported difficulties associated with offering GME training in rural areas, as well as using Medicare funding to support rural GME training."

Recognizing the problems identified by the GAO, the Council on Graduate Medical Education (COGME) recommends that "CMS and other agencies could create other incentives that permit rural hospitals to establish fair 'total resident amounts' for GME funding and decrease the disparities between urban and rural funding."[ii]

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The Rural Physician Workforce Production Act of 2021 addresses these concerns in four ways:

- It creates an adequate, alternate payment for training in rural settings
- It allows for expansion of training in rural settings and supports rural experiences for residents whose home training program is not in a rural location, and
- It removes current Medicare cap and payment limitation requirements that make it not financially viable for rural and urban hospitals to expand or create new rural training track residency programs or experiences.
- It includes new definitions for rural settings to capture appropriate rural training.

Thank you again for your leadership in introducing this much needed legislation. The CAFM organizations and our members are pleased to work with you to secure its enactment.

Sincerely,

Aaron Michelfelder, MD
President
Society of Teachers of
Family Medicine

Wendy Barr, MD
President
Association of Family
Medicine Residency Directors

Chelley Alexander, MD
President
Association of Departments
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Gillian Bartlett, PhD
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North American Primary Care
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[i] Government Accountability Office, Physician Workforce: Location and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs, GAO-17-411, May 2017, at 25-26

[ii] Council on Graduate Medical Education. Investing in a Health Workforce that Meets Rural Needs. Feb 2021. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-issue-brief.pdf