AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

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June 24, 2024

VIA ELECTRONIC SUBMISSION

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

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

The Honorable Robert Menendez
United States Senate
Hart Senate Office Building
Washington, D.C. 20510

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

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

The Honorable Thom Tillis
United States Senate
Dirksen Senate Office Building 113
Washington, D.C. 20510

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

The Honorable Marsha Blackburn
United States Senate
Dirksen Senate Office Building 357
Washington, D.C. 20510

Dear Chairman Wyden and Senators Cornyn, Menendez, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

The American College of Osteopathic Family Physicians (ACOFP) appreciates the opportunity to respond to the Senate Finance Committee's Policy Outline on Graduate Medical Education (GME). ACOFP is the professional organization representing more than 26,000 practicing osteopathic family physicians, residents, and students throughout the U.S. who are committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care. We applaud the Committee's leadership in recognizing primary care physician shortages and supporting the increase in residency positions for this specialty within the Medicare graduate medical education (GME) program, especially in rural and underserved areas. Our responses to the questions below highlight the need for protecting and expanding medical education funding in rural and underserved areas as well as ensuring access to primary care services to improve patient care.

To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?

ACOFP supports the proposal to add additional Medicare GME slots for fiscal year (FY) 2027-2031. However, we strongly urge the Committee to reexamine and explore opportunities to reform the GME program to more accurately reflect workforce needs. Specifically, we recommend that primary care residency slots, including family medicine, account for 50 percent of total residency slots. This would reflect population needs. The Committee's current provision would distribute at least 25 percent of new Medicare GME slots towards primary care residencies. While we support efforts to increase GME slots, 25 percent is not sufficient. As more family physicians reach retirement age, the U.S. is facing shortages of 18,000–48,000 primary care physicians by 2034.[1] More needs to be done to address this shortage and increase the number of residents choosing primary care, including family medicine. Increasing GME slots specifically for primary care can play an essential role in addressing this shortage.

Further, we highlight that there is a growing percent of osteopathic physicians who are choosing primary care careers – reflecting our overall mission of serving the whole patient. Distributing more residency slots for primary care would help ensure that these physicians have access to training opportunities. We urge the Committee to consider this trend and support our efforts to ensure rural and underserved patients have access to family physicians. In addition, a higher rate of osteopathic family physicians is returning to rural communities to practice family medicine. ACOFP is committed to ensuring there is an adequate pipeline of family physicians in rural and underserved areas, but federal leadership and support is essential.

How could Congress improve the recruitment of physicians to work in rural or underserved communities?

Congress can take a number of steps to improve the recruitment of physicians to work in rural or underserved communities. ACOFP urges the Committee to consider legislation to address physician shortages, which especially impact rural and underserved areas. Specifically, ACOFP supports the *Rural Physician Workforce Production Act of 2023* (S. 230 / H.R. 864), which would provide solutions to physician shortages such as establishing a Medicare GME methodology for hospitals training rural residents, enabling hospitals such as critical access hospitals (CAHs) and sole community hospitals (SCHs) to receive Medicare GME funding under this new methodology, and allowing for the growth of rural resident training programs under the Medicare program. This legislation is an important step toward strengthening the physician workforce in rural and underserved communities, especially since residents tend to practice where the train.

Also, ACOFP supports the *Community TEAMS Act of 2024*, which would prepare medical students to serve high-need communities after graduation by enabling them to train in these communities. The more exposure medical students get to underserved and rural communities will increase the possibility of graduates staying in that type of practice and community. This legislation is critically important and well-timed, as our country faces a physician shortage, particularly in rural and underserved areas.

Another critical component of supporting the future family physician workforce is to appropriately incentivize primary care careers. The Committee should explore ways to expand loan repayment and forgiveness programs. For example, many states have loan forgiveness programs for physicians that

[1] *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034.* Association of American Medical Colleges. June 2021. Accessed January 12, 2023. https://www.aamc.org/media/54681/download.

serve in a rural area for a specified time period. Other successful loan forgiveness programs encourage local students to pursue a career in healthcare in the community. Programs like these are powerful incentives for students to practice in rural areas. Moreover, the Committee should explore policies to enhance Medicare reimbursement rates in rural settings that align with urban settings. Primary care physicians are more likely to serve in rural areas if they are paid similar to their urban counterparts.

The Committee should also consider provisions to address administrative burden. Such burdens have a disproportionate impact on physicians in independent solo and small practices, including those in rural and underserved communities, where they do not have the resources to manage all these paperwork requirements. This makes it even more difficult to recruit to these communities given administrative burden is exacerbated by limited resources.

Finally, ACOFP believes it is important to ensure that there are opportunities and support for residents. We urge the Committee to consider requiring medical schools to sponsor as many residency positions as there are graduates and ensure such positions are available in rural and underserved areas. The Committee should also establish requirements that if a program closes, it is the responsibility of the program, rather than the resident, to find new positions for residents.

Should guardrails be put in place to ensure patient outcomes and a resident's educational experience are not negatively impacted by an extension of flexibilities that allow teaching physicians to use telehealth to train resident physicians?

ACOFP supports telehealth flexibilities that allow teaching physicians to use audio/video real-time communications technology to supervise the training of resident physicians. However, the Committee should be mindful when proposing such legislation to ensure that resident physicians still receive sufficient in-person training. The legislation should include guardrails, including specific requirements for the number of hours that resident physicians must receive in-person versus via audio/video real-time communications technology. Telehealth should supplement the training that resident physicians receive and should not be the only form of training. Resident physicians receiving proper training will ensure that patients receive the best possible care from their physicians.

In addition to guardrails for extending telehealth flexibilities, the Committee should consider provisions to address other factors that impact residents' education experience. We are concerned that some of the rural teaching hospitals where the resident physicians are being trained do not have updated equipment. Unfortunately, many smaller rural regions do not have the funds to keep pace with the advancements in technology. We urge the Committee to consider provisions that would address this issue in order to ensure that residents have access to train with equipment reflect the current best practices of patient care.

What other telehealth flexibilities should the working group consider that would benefit resident physicians who are being trained in teaching hospitals, particularly those located in rural or underserved areas?

As previously noted, ACOFP supports telehealth flexibilities that allow teaching physicians to use audio/video real-time communications technology to supervise the training of resident physicians. This is especially important for resident physicians working in rural and underserved areas who do not have the same training available as resident physicians in more urban areas.

In addition to supporting telehealth flexibilities that assist with the training of resident physicians, ACOFP supports greater access to care and strongly believes that expanded access to telehealth services helps ensure that patients receive necessary treatment, even if they are unable to see a

provider in person. Expanded telehealth services also has the added benefit of improving health equity, as patients with disabilities and limited means of transportation have more opportunities to interact with their providers.

Telehealth provided by a patient's established provider can be a powerful tool for care delivery due to its potential to improve access to care for countless Americans. Telehealth flexibilities would be especially beneficial for resident physicians who are being trained in teaching hospitals, especially those located in rural and underserved areas, given that it increases access to the most vulnerable patients. The Committee should advance legislation that would increase access to telehealth by removing regulatory barriers. For example, there are many Medicare reimbursement policies (e.g., geographic and originating site restrictions) that limit the full potential of telehealth.

While we support increased telehealth flexibilities, we also want to highlight the importance of existing physician-patient relationships and care coordination. ACOFP believes telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth. We want to avoid situations where a patient receives care via telehealth, but there is no follow up or coordination with existing in-person providers afterward. We also want to ensure equitable access so that patients who might need it most, specifically those in rural or underserved areas, are able to maximize telehealth opportunities while not sacrificing the physician-patient relationship. In addition, while ACOFP supports the use of telehealth, it is also important to maintain protections to guard against fraudulent activity.

Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?

ACOFP supports legislation that would require the Secretary of Health and Human Services (HHS) to establish a GME Policy Council consisting of nine members representing academic medical institutions, hospitals that serve rural areas and underserved communities, medical students, and health care workforce experts to evaluate the distribution of new Medicare GME slots made available.

We also urge the Committee to create a requirement that would ensure that primary care, including family medicine, is adequately represented on the GME Policy Council. This is especially important to ensure that the primary care physician community has a voice in the evaluation of the distribution of new Medicare GME slots.

Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?

ACOFP supports the provision to reset the low GME caps of certain hospitals, which includes providing 10 years rather than five years for eligible hospitals to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap. We also support the statutory change for certain hospitals that have had low PRA or FTE caps for a period of 20 cost reporting periods. ACOFP supports permitting hospitals to be eligible to reset their low GME caps, including additional hospitals not specifically included in the proposal. In order to meet the goal of ensuring an adequate physician workforce, these hospitals should be given as much flexibility as possible to establish new GME caps.

What additional policies should Congress consider to improve the distribution of unused GME slots to areas facing the greatest projected shortage of physicians?

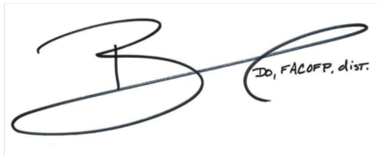
ACOFP supports the proposal to amend the current process for distributing GME slots from hospitals that close their residency programs. We believe that removing the requirement that CMS prioritize

hospitals in the same region of the country as the closed hospital when distributing slots from these closed hospitals to expand the reach of these newly available slots would ensure that hospitals most in need of the GME slots will receive them. This is especially important for hospitals in rural and underserved areas that are in need of GME slots but may not be considered in the redistribution of the GME slots because they are not in the same region of the county as the closed hospital.

In addition, ACOFP supports the proposal that would require hospitals to demonstrate a likelihood of starting to use these positions within two years and to fill the positions within five years. This creates accountability for hospitals to ensure that the GME slots that have been redistributed are being utilized.

Thank you for your leadership in addressing the workforce challenges that osteopathic family physicians face in our health care system. ACOFP is committed to working with the Committee to take steps to address the physician workforce shortage and increase Medicare GME slots for primary care, including in rural and underserved areas, for to improve patient access to care.

Sincerely,



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