acofp | AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
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January 27, 2025

VIA ELECTRONIC SUBMISSION

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

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

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

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

Dear Senators Cassidy, Cortez Masto, Cornyn and Bennet:

The American College of Osteopathic Family Physicians (ACOFP) appreciates the opportunity to provide feedback on the draft legislative proposal to improve the Medicare Graduate Medical Education (GME) program. 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 Medicare GME Working Group's (Working Group's) leadership in recognizing primary care physician shortages and promoting the increase in residency positions for this specialty within the Medicare GME program, especially in rural and underserved areas. Our responses to the questions below highlight the need for ensuring access to primary care services to improve patient care and protecting and expanding medical education funding in rural and underserved areas.

Is the 30-slot cap appropriate for ensuring fair distribution of residency slots across hospitals? What other strategies could Congress consider to ensure hospitals in all regions have an equal opportunity to compete for slots?

ACOFP supports the proposal to add additional Medicare GME residency slots for fiscal year (FY) 2027-2031. We believe a cap is appropriate to ensure a broad distribution of residency slots under the legislation; however, we strongly urge the Working Group to reexamine and explore opportunities to reform the GME program to more accurately reflect primary care physician workforce needs. The Working Group's proposal would distribute at least 25 percent of new Medicare GME residency positions towards primary care residencies. While we support efforts to increase primary care GME residency slots, we urge the Working Group to increase the percentage of distributed residency slots that are allocated for primary care.

As more family physicians reach retirement age, the U.S. is facing shortages of 18,000 to 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 residency slots specifically for primary care would play an essential role in addressing this shortage.

Also, osteopathic family physicians are committed to addressing this shortage and ensuring that there is access to primary care especially in rural and underserved areas. In fact, a growing number of osteopathic physicians are choosing primary care physician 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 primary care training opportunities. In addition, a higher rate of osteopathic family physicians are practicing family medicine in rural and underserved areas. ACOFP is committed to ensuring there is an adequate pipeline of family physicians, but federal leadership and support is essential. We urge the Working Group to consider these trends and support our efforts to ensure access to primary care especially in rural and underserved areas.

In ACOFP's response to the Working Group's Policy Outline on GME, we recommended that primary care residency slots, including family medicine, account for at least 50 percent of total distributed residency slots. We reiterate this recommendation because it would address population needs.

Is codifying remote supervision the best way to provide flexibility to rural hospitals, or are there alternative approaches Congress should consider?

ACOFP supports the Working Group's proposal to extend the telehealth flexibility that allows teaching physicians to supervise resident physicians remotely through audio/video real-time communications technology beyond January 1, 2026. This flexibility is especially helpful for physicians in rural hospitals given it can help expand access to care and is especially important for resident physicians working in rural and underserved areas who may not have the same training opportunities available as resident physicians in more urban areas.

However, ACOFP believes that there are other considerations that the Working Group should keep in mind as it drafts the legislation, which we also highlighted in our response to the Working Group's Policy Outline on GME. Specifically, we urge the Working Group to revise the legislation to ensure that resident physicians still receive sufficient in-person training because training through telehealth should supplement instead of replace the in-person training that resident physicians receive and therefore should not be the only or primary form of training. For example, 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. Resident physicians receiving appropriate training will ensure that patients receive the best possible care from their physicians.

In addition to guardrails for extending telehealth flexibilities, the Working Group should consider provisions to address other factors that impact residents' educational experiences. Specifically, we are concerned that some of the rural teaching hospitals where the resident physicians are being trained do not have up-to-date equipment. Unfortunately, many smaller rural hospitals do not have sufficient resources to maintain access with technological innovations. We urge the Working Group to consider the creation of programs, including grant programs or additional Medicare reimbursement, that provide these providers with resources to ensure residents have access to train with equipment that reflect the current best practices of patient care.

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[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.

Is creating a GME Policy Council the right approach to guiding future GME slot allocations? Is the scope and responsibility of the Council adequate to make it effective?

ACOFP supports legislation that would require the Secretary of Health and Human Services (HHS) to establish a GME Policy Council, including representatives from academic medical institutions (including one MD and one DO school), hospitals serving rural and underserved areas, medical students, healthcare workforce experts, and at least one MD and one DO. We believe that the GME Policy Council is an appropriate approach to guide future GME slot allocations. However, to be more effective, we urge the Working Group 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 when evaluating how to distribute new Medicare GME slots.

Additional Feedback

Steps to improve the recruitment of physicians to work in rural or underserved communities

We applaud the Working Group for addressing the challenges rural hospitals face in supporting residency programs by proposing to allow Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs) to receive IME payments to support the cost of training residents in rural areas given that SCHs and MDHs receive Medicare Direct GME (DGME) payments, but not all receive IME payments.

In our response to the Working Group's Policy Outline on GME, we provided feedback on how to improve in the physician workforce pipeline especially in rural and underserved communities. We reiterate this feedback below and urge the Working Group to consider including these recommendations in the draft legislation.

First, ACOFP believes Congress can take a number of steps to improve the recruitment of physicians to work in rural or underserved communities. Specifically, ACOFP supports the *Rural Physician Workforce Production Act of 2023*, which would provide solutions to physician shortages such as establishing a Medicare GME methodology for hospitals training rural residents, enabling hospitals such as CAHs and SCHs to receive Medicare GME funding under this new methodology and allowing for the growth of rural resident training programs under the Medicare program. 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 them 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.

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

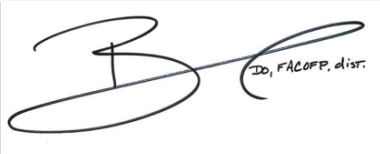
The Committee should also consider provisions to address administrative burden. Such burdens have a disproportionate impact on physicians in independent, solo and small practices, including those in

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 in 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.

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 Working Group to take steps to address the physician workforce shortage and increase Medicare GME slots for primary care, including in rural and underserved areas, to improve patient access to care.

Sincerely,



Brian Kessler, DO, DHA, FACOFP, *dist*.
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