June 5, 2020

The Honorable Mitch McConnell
Senate Majority Leader
United States Senate
S-230, US Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
H-222, US Capitol
Washington, DC 20510

The Honorable Charles E Schumer
Senate Minority Leader
United States Senate
S-221, US Capitol
Washington, DC 20510

The Honorable Kevin McCarthy
House Minority Leader
United States House of Representatives
H-204, US Capitol
Washington, DC 20510

Dear Speaker Pelosi, Majority Leader McConnell, Minority Leader McCarthy, and Minority Leader Schumer,

Thank you for your rapid response thus far to the continued spread of coronavirus (COVID-19). We are writing on behalf of the Council of Academic Family Medicine (CAFM) which collectively includes family medicine medical school and residency faculty, community preceptors, residency program directors, medical school department chairs, research scientists, and others involved in family medicine education. CAFM offers the following specific suggestions for legislative relief to allow for short term research and service delivery in rural and underserved areas.

Policy Proposals to Combat COVID-19's Harmful Impact on Primary Care Training

The COVID-19 pandemic has caused an unprecedented upheaval in our health system. In each sphere of care, new pressures and changes have required innovation and adaptation. CDC data show that among known COVID-19 patients, just over 80% remain in ambulatory care, and do not require hospitalization[i]. The ambulatory care space has been deeply affected by COVID-19 and the impact on primary care and family medicine needs to be evaluated regarding new payment changes, training, care modalities and research. Below are four areas that we believe Congress should address in its next COVID-19 package to address both impact and recovery. These recommendations mainly relate to academic or training aspects of primary care practice.

Executive Summary:

Rural Hospital Bonus Payment to Help Retain Current Rural Training Programs:
We propose a bonus payment to rural hospitals that maintain their current residency training programs. This will help rural hospitals struggling under COVID currently training residents who are likely to go into rural practice and who supply a significant portion of the future workforce serving those hospitals. The proposed payment is not a payment for ongoing graduate medical education (GME), rather it is an incentive payment to a rural hospital that commits to maintain their current training program(s) within the difficult COVID-19 environment. Although the payment is determined by the number of resident positions, it is not a payment for residency education. A rural hospital which serves as the primary location of training greater than 50 percent of residents' time would receive the bonus payments upon agreeing to maintain its training program(s) for the next three academic years.

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Provide Refundable Tax Credits for Primary Care Volunteer Community Preceptors:
In order to help maintain primary care training in the community, we recommend providing a refundable tax credit to volunteer, or uncompensated preceptors, to help increase the ability of primary care physicians to provide appropriate, quality ambulatory experiences, especially in rural areas.

Primary Care/Ambulatory COVID-19 Research Funding:
Provide additional $130 million in new funding for the Agency for Healthcare Research and Quality (AHRQ.) We request $80 million -- for telehealth questions and general broad-based study on training needs (workforce). We also request $50 million -- on questions of deferred primary care, practice changes and training and supervision, physical and emotional burden on providers, patients, community; analyses regarding reduction in necessary versus unnecessary services, and to address the special needs for rural and underserved areas.

Workforce Needs Related to Primary Care under Title VII, Primary Care Training and Enhancement Program:
Provide $125 million in new funding for Title VII, Section 747 (Primary Care Training and Enhancement.) This funding should be directed to both residencies and departments, to deal with issues related to faculty retention, public health competencies, recruitment, and retention of students into primary care. This funding would also develop new curriculum in this regard as well as other curriculum related to the pandemic and to address the segmented primary care workforce in an effort to reduce delivery system division.

I. Rural Hospital Bonus Payment to Help Retain Current Rural Training Programs:

Many primary care practices are experiencing tremendous financial hardship, and many are shutting their doors or laying off staff due to the impact of COVID-19 on the primary care workforce. Recent COVID-19 legislation helped some of these practices financially, but little attention was paid regarding the impact of training future primary care physicians, especially in rural America. Below is a new legislative proposal to aid in the retention of a meaningful training framework for rural primary care.

Background: Rural hospitals were under immense financial pressures prior to COVID-19. Over 100 rural hospitals have closed since 2013.[ii] Current Medicare GME payments have not reimbursed rural hospitals adequately; consequently, hospitals need to subsidize these payments in order to support residency training. The data show that training in rural areas increases the likelihood of practice in rural areas.[iii] Training in rural settings is associated with a two- to three-fold increased likelihood of rural practice.[iv] COVID-19 has exacerbated these problems.

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.

Proposal: We propose a bonus payment to rural hospitals that maintain their current residency training programs. This will help rural hospitals currently training residents who are likely to go into rural practice and who supply a significant portion of the future workforce serving those hospitals. Data from a recent study of Family Medicine Rural Training Track graduates showed percentages ranging from 32.3% to 40.0%, with most above 35% in six of the seven post-graduate years.[v] This compares very favorably to the current 9%of all physicians currently in rural practice.

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. Although the payment is determined by the number of resident positions, it is not a payment for residency education. 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.

Data and Cost:

Total Cost: Our proposal would have a cost of approximately $88.35 million, supporting 90 rural hospitals across 39 states.

Data: There are currently about 1860 family medicine and internal medicine residents training for greater than 50% of their training time in rural hospitals (defined by the rural urban community area or RUCA code[vi] of 4.0 or higher.) There are 192 residents training in other specialties in hospitals in rural areas: general surgery, psychiatry, pediatrics and OB-GYN. Twelve hospitals have more than one program, so we would cap funding for those hospitals at the equivalent of 36 residents. One hospital is closing as of July 30, consequently closing its family medicine residency as well, accounting for 18 residents. In addition, one rural hospital which hosts a training program is a VA hospital, which we are excluding. This leaves approximately 1,767 residents to be counted for the bonus payment.

If each rural hospital were paid an additional $50,000 per resident, (with the caveats mentioned above) the total cost would be approximately $88.35 million. Each hospital must commit to retaining the training program(s) for three years. Most family medicine rural programs train between 2 and 6 residents, so many rural hospitals serving as a primary location of family medicine training would receive up to $300,000.

Eligibility:

- The rural hospital must be the primary rural training location for residents in a separately accredited rural training program (where residents spend more than 50% of their training time.)
- It must be situated in a location that is categorized as a rural-urban commuting area (RUCA) code of 4 or greater.
- It must agree to maintain its training program for the next three academic years.
- Institutions with more than one residency program would have the bonus payment capped at the equivalent of 36 residents ($1.8 million).
- Veterans Administration (VA) Medical Centers would be excluded from this payment as they already are supported by federal funding.

II. Provide Refundable Tax Credits for Primary Care Volunteer Community Preceptors:

Background: While most resident training occurs in hospital settings, one of the hallmarks of family medicine training is ambulatory training in non-hospital, community settings. This applies to both residents and medical student training. For medical students, their clinical rotations (clerkships) in family medicine and primary care are predominantly centered in community physicians' offices. A preceptor is a physician or other clinical provider who provides a mentoring experience of several weeks, including a program of personalized instruction, training, and supervision at an ambulatory location to medical or other health professions students.

Providing this mentoring and supervision has costs associated with it; uniquely, this training has typically been accomplished by volunteer preceptors that choose to absorb costs because they like teaching and/or want to give back. However, as practices scramble to hold together their financial well-being given

the impact of COVID-19 on their practices, it is increasingly more difficult to continue providing this free service. The medical student component is especially costly as the incorporation of students in the practice slows it down, reducing patient visit income. In normal times it is difficult for medical schools to identify enough community preceptors to provide quality ambulatory, community-based training. The pandemic has made this process even more difficult.

Proposal: In order to help maintain primary care training in the community, we recommend providing a refundable tax credit to volunteer, or uncompensated preceptors, to help increase the ability of primary care physicians to provide appropriate, quality ambulatory experiences, especially in rural areas.

III. Primary Care/Ambulatory COVID-19 Research Funding

Proposal: Provide additional $130 million in new funding for the Agency for Healthcare Research and Quality (AHRQ.) We request $80 million -- for telehealth questions and general broad-based study on training needs (workforce). We also request $50 million -- on questions of deferred primary care, practice changes and training and supervision, physical and emotional burden on providers, patients, community; analyses regarding reduction in necessary versus unnecessary services, and to address the special needs for rural and underserved areas. For more specific content of our requests, see below:

In AHRQ's 1999 reauthorization, Congress stipulated that AHRQ's Center for Primary Care Research "shall serve as the principal source of funding for primary care practice research in the Department of Health and Human Services." 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 doesn't – in health care delivery. We need AHRQ to address practice and questions that COVID-19 has brought to light and also those related to training primary care physicians for the future.

There are multiple areas for which research is needed in the primary care/ambulatory COVID-19 space.

- Evaluations and research related to primary care clinical research and the health care system's response to the COVID-19 virus. AHRQ should perform additional research regarding care provision in the ambulatory setting that includes mechanisms and best practices related to incorporating learners (medical students and residents), particularly around appropriate supervision.

- System-wide research to evaluate the impact of the pandemic on primary care practice and training. AHRQ should focus on issues such as the most effective public health primary care partnerships and support strategies; payment, technology, and operations in primary care; immediate and long-term workforce mechanisms best suited to respond emergently, and best practices to keep the chronically ill out of emergency departments. Additional questions such as primary care's role in contact tracing, surveillance, eventual prioritization of vaccine distribution and generally the integration of primary care and public health need to be studied.

- Research into appropriate ambulatory care for patients with COVID-19. We do not know enough about what care is appropriate, needed, and how to provide it. Moreover, the behavioral health needs of caring for patients with COVID-19 (and

those without) to help allay the huge increases in anxiety, depression, and panic must be explored. Related clinical symptoms such as headache, utilization and co-infections, the differentiation between influenza and COVID-19, and the screening family members for the infection, are all COVID-19-related questions in the primary care space.

- Deferred primary care. For the past three months, primary care practices have, in many cases, been shuttered, providing only telehealth in much reduced capacity. Primary care physicians, especially in teaching hospitals, have been tasked with supporting hospital efforts at screening for COVID-19. 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 (more telehealth, reduced in person care, etc.) 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. Research could include best practices used in other countries as well as evaluating state models.

- Primary care practice during the crisis. Research could address identifying non-essential/non-evidence-based procedures; diagnostic testing, criteria for in person vs. telehealth visits and appropriate ways to practice at the top of the license during the pandemic, and afterwards.

- Telehealth best practices for primary care physicians and residents to learn to and deliver services with a focus on telehealth. What changes incorporated in the public health emergency should be retained, what training needs related to public health are needed, and how much telehealth should be longitudinal? Without medical therapies, a cure, or a vaccine the continuity relationship is a key feature in providing appropriate high-quality care. Identifying and removing barriers to provision of longitudinal care through telehealth is critical. Moreover, specific attention to study how to reach rural and underserved areas, including patients with limited video/broadband resources through telehealth mechanisms is needed.

IV. Workforce Needs Related to Primary Care under Title VII, Primary Care Training and Enhancement Program

Provide $125 million in additional, new funding for Title VII, Section 747 (Primary Care Training and Enhancement.) This funding should be directed to both residencies and departments, to deal with issues related to faculty retention, public health competencies, recruitment and retention of students into primary care, to develop new curriculum in this regard as well as other curriculum related to pandemic, and address the segmented primary care workforce in an effort to reduce delivery system division and increase full scope primary care providers. Specifically, funding is needed for the following:

- 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. Additional Title VII, Section 747 funding could be used to identify appropriate training needs to retrain primary care providers to support our nation's inpatient care needs.

- Evaluate the highly segmented primary care physician workforce and make recommendations to reverse unnecessary delivery system division and increase full scope primary care providers.

- 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.

Thank you for considering our requests. If you have questions, please contact Hope Wittenberg, Director, Government Relations at 703-731-8200 or hwittenberg@stfm.org.

Sincerely,

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[i] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
[ii] https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ Accessed 5-29-2020
[iii] https://pubmed.ncbi.nlm.nih.gov/24364487/?dopt=Abstract
[iv] http://depts.washington.edu/uwrhrc/uploads/RHRC_FR126_Chen.pdf
[v] Patterson DG, Schmitz D, Longenecker R, Andrilla CHA. Family medicine Rural Training Track residencies: 2008-2015 graduate outcomes. Seattle, WA: WWAMI Rural Health Research Center, University of Washington. Feb 2016.
[vi] https://depts.washington.edu/uwruca/ruca-codes.php