

November 26, 2019

The Honorable Danny Davis
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Brad Wenstrup
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Terri Sewell
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

The Honorable Jodey Arrington
Committee on Ways and Means
U.S. House of Representatives
Washington, DC

Dear Representatives Davis, Sewell, Wenstrup and Arrington:

Thank you for the opportunity to respond to the Committee's Request for Information Regarding Rural Health. The Council of Academic Family Medicine (CAFM) 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. Our expertise in the area of health care in rural communities is mainly related to workforce issues and the importance of increased access to primary care physicians to health outcomes, so our response to your solicitation focuses on workforce, and the health impact of increased primary care production and access.

Since we only responded to these two intertwined areas, we used more than 250 words each, but kept in mind the Committee's need for brevity.

1. What are the main health care-related factors that influence patient outcomes in rural and/or urban underserved areas?

There is strong evidence of the benefits of primary care for both population and personal health. Studies show that robust systems of primary care can improve health -- access to primary care can lower overall health care utilization, increase the use of preventive services, and lower disease and death rates. Primary care may reduce the negative health effects of income inequality on health and mortality, especially in areas where income inequality is greatest.ⁱ

The current physician shortage and uneven distribution of physicians impacts population health. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.ⁱⁱ The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).ⁱⁱⁱ These findings are consistent with numerous others on health equity, including a study published in *JAMA Internal Medicine*, indicating that a person's zip

code may have as much influence on their health and life expectancy as their genetic code.^{iv} Therefore, it is imperative that primary care is accessible to all.

6. What successful Models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?

A 2013 Academic Medicine report on Graduate Medical Education (GME) accountability shows that only 4.8% of all graduates of 759 sponsoring institutions practiced in rural areas. This percentage compares extremely unfavorably to the 19.3% of the population classified as rural by the 2010 census.^v In comparison, family medicine graduates of residency training programs tend to practice close to where they train. 2009 data from the American Medical Association Physician Masterfile show that 56% of family medicine residency program graduates practice within 100 miles of their residency program. Of note, 19% locate within five miles, and 39% locate within 25 miles of their residency program^{vi}.

When Congress enacted the Balanced Budget Act (BBA) of 1997, a law that put in place limits on Medicare funded residency positions or slots, there was clear intent in both the statute and the report language to treat rural training differently and provide special consideration to meet the needs of underserved rural areas. Unfortunately, the technicalities of the statute, and the regulations deriving from it, have not succeeded in achieving this intent.

Our recommendations below stem from our belief that Medicare statute and regulations relating to GME should be amended – with a goal to promote growth in rural physician training, rather than hinder or limit it.

Successful Models:

Rural Training Tracks: One successful model of training is the Rural Training Track (RTT), defined as a residency program where residents train for more than 50% of their time in rural locations in outcomes and retention. These RTTs, according to a 2016 study^{vii}, show outcomes relating to rural practice at twice the rate of family physicians in general. Moreover, 56% of RTT graduates provided health care in primary care Health Professional Shortage Areas (HPSAs) one-year post-graduation and by seven years postgraduation, 50% were still in primary care HPSAs. These graduates' practice choices persist over time, as well. The committee should encourage expansion of the RTT model, including lifting obstacles to their growth, both in terms of limits on numbers of residency slots (caps) for RTT training as well as reimbursement for such training.

Teaching Health Center program. While other residency programs base training out of hospitals, the Teaching Health Center Graduate Medical Education (THCGME) programs focus training in community-based primary care settings, such as Federally Qualified Health Centers (FQHCs). The THCGME program has used a national per resident amount for reimbursement for training since its inception. This is a successful model – only hampered by the lack of consistency and adequacy of the payment over time due to its status as an appropriated program. Funding THCs as an entitlement rather than an appropriation, while keeping current structure and accountability under HRSA, would solve the financial instability and allow growth in such centers, producing more primary care physicians in rural and urban underserved areas.

Establishment of a national per resident amount: Similarly, establishing a national per resident payment amount for reimbursement for rural residency training that is not based on Medicare formulas, and not reduced by Medicare's "share" is necessary for increased production of rural physicians. We have had decades of experience with the Medicare GME reimbursement model; it

does not adequately support training and production of physicians for rural America. An alternative would be to utilize an optional national per resident payment to replace Medicare GME (both DME and IME) payments under existing law to pay for the full costs of training residents in rural areas.

On behalf of CAFM, thank you again for the opportunity to respond to the Request for Information. Please contact me if you have any questions regarding this response.

Sincerely,

A handwritten signature in black ink that reads "Hope R. Wittenberg". The signature is fluid and cursive, with a long horizontal stroke at the end.

Hope Wittenberg
Director, Government Relations

ⁱ 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. (Robert Graham Center)

ⁱⁱ Moy E, Garcia MC, Bastian B, et al, Leading Cause of Death in Nonmetropolitan and Metropolitan Areas – United States, 1999 – 2014, MMWR, Surveil Summ, 2017; 66 (No.SS-1); 1-8. DOI: <https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm>

ⁱⁱⁱ MMWR, 2017

^{iv} Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Mackenbach JP, van Lenthe FJ, Mokdad AH, Murray CJL. Inequalities in Life Expectancy Among US Counties, 1980 to 2014 Temporal Trends and Key Drivers. *JAMA Intern Med.* 2017;177(7):1003–1011. doi:10.1001/jamainternmed.2017.0918

^v Chen C, Petterson S, Phillips RL, Mullan F, Bazemore A, O'Donnell SD. Toward graduate medical education (GME) accountability: measuring the outcomes of GME institutions. *Acad Med.* 2013;88(9):1267-80.

^{vi} E. Blake Fagan, Md; Sean C. Finnegan, Ms; Andrew W. Bazemore, Md, Mph; Claire B. Gibbons, Phd, Mph; And Stephen M. Petterson, Phd *Am Fam Physician*. 2013 Nov 15;88(10):704

^{vii} https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/02/RTT_Grad_Outcomes_PB_2016.pdf