AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Congressional Primary Care Caucus

RECOMMENDATION
The American Academy of Family Physicians (AAFP) recommends that House members join the Congressional Primary Care Caucus.

Background
The AAFP believes that this bipartisan caucus will make great strides in educating legislators, staff, and the public on primary care issues, experiences, and concerns such as:

- Information Congress needs to know about what primary care is and the value it creates.
- Strategies to build the primary care physician workforce and to maintain an appropriate balance between primary care and subspecialty care physicians.
- Program and policy changes the government can make to increase primary care access and training, especially in underserved communities.
- Reforms needed to the Graduate Medical Education (GME) program to support the education and training of primary care physicians.
- Policy changes to improve telehealth services in the primary care setting.
- Steps for the government to harmonize quality improvement efforts among different payers.

In 2016 during the 114th Congress, Reps. David Rouzer (R-NC) and Joe Courtney (D-CT) launched the Congressional Primary Care Caucus (http://www.aafp.org/advocacy/track/primary-care-caucus.html). In announcing the formation of the caucus, the co-chairs said that they would "focus on educating members of Congress and the public about the value and importance of a comprehensive, coordinated and connected primary care system."

In the 116th Congress, the Primary Care Caucus is again dedicated to advancing public policy that establishes, promotes and preserves a well-trained, high-quality primary care workforce and delivery system as the foundation of our nation's health care system. The caucus focuses its efforts on the advancement of primary care that is comprehensive in the delivery of services; continuous in caring for patients over time; connected to other health and community services; equitable to all regardless of age, race or gender; and mindful of social conditions that may hinder access to primary care.

A large body of research proves that establishing a relationship with a primary care physician or other primary care provider is one of the most reliable determinants of better health outcomes. Yet the U.S. health care system significantly undervalues primary care. For example, the Medicare Payment Advisory Commission, a Congressional advisory entity, recently reported that the current Medicare physician fee schedule undervalues primary care relative to specialty care, noting a difference of nearly $300,000 in annual compensation between a family physician and a cardiologist. This bias for specialty medicine drives student interest and further skews the ratio of primary care physicians to specialists.

The Congressional Primary Care Caucus also focuses its attention on the growing relative shortage of primary care physicians and other providers and brings together legislators and staff who are interested in addressing policy proposals that could mitigate this shortage.

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Roster of the Congressional Primary Care Caucus
116th Congress (as of May 2019)

1. **Joe Courtney, Co-Chair (D-CT)**
2. **David Rouzer, Co-Chair (R-NC)**
3. Ralph Abraham, MD (R-LA)
4. Robert Aderholt (R-AL)
5. Ami Bera (D-CA)
6. Earl Blumenauer (D-OR)
7. Lisa Blunt Rochester (D-AL)
8. Suzanne Bonamici (D-OR)
9. Julia Brownley (D-CA)
10. Andre Carson (D-IN)
11. Kathy Castor (D-FL)
12. David Cicilline (D-RI)
13. Steve Cohen (D-TN)
14. Chris Collins (R-NY)
15. J. Luis "Lou" Correa (D-CA)
16. Susan Davis (D-CA)
17. Peter DeFazio (D-OR)
18. Rosa DeLauro (D-CT)
19. Mike Doyle (D-PA)
20. Jeff Fortenberry (R-NE)
21. Ruben Gallego (D-AZ)
22. Andy Harris, MD (R-MD)
23. Alcee Hastings (D-FL)
24. Denny Heck (D-WA)
25. Jaime Herrera Beutler (R-WA)
26. Jim Himes (D-CT)
27. Eleanor Holmes Norton (D-DC)
28. Bill Huizenga (R-MI)
29. Pramila Jayapal (D-WA)
30. John Joyce, MD (R-PA)
31. Joseph P. Kennedy (D-MA)
32. Dan Kildee (D-MI)
33. Derek Kilmer (D-WA)
34. Steve King (R-IA)
35. Raja Krishnamoorthi (D-IL)
36. John Larson (D-CT)
37. Dave Loebsack (D-IA)
38. Alan Lowenthal (D-CA)
39. Blaine Luetkemeyer (R-MO)
40. Ben Ray Lujan (D-NV)
41. Roger Marshall, MD (R-KS)
42. James P. McGovern (D-MA)
43. Seth Moulton (D-MA)
44. Dan Newhouse (R-WA)
45. Chellie Pingree (D-ME)
46. Mark Pocan (D-WI)
47. David Price (D-NC)
48. Jamie Raskin (D-MD)
49. Lucille Roybal-Allard (D-CA)
50. Raul Ruiz, MD (D-CA)
51. Jan Schakowsky (D-IL)
52. Brad Schneider (D-IL)
53. Jason Smith (R-MO)
54. Steve Stivers (R-OH)
55. Paul Tonko (D-NY)
56. Norma Torres (D-CA)
57. Michael Turner (R-OH)
58. Greg Walden (R-OR)

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Graduate Medical Education

RECOMMENDATION
The American Academy of Family Physicians (AAFP) recommends that Congress reform Medicare Graduate Medical Education financing to address inequities, improve accountability and train more family physicians. The AAFP urges legislators to cosponsor the Advancing Medical Resident Training in Community Hospitals Act (HR 1358) and the Rural Physician Workforce Production Act (S 289).

Background

The federal government annually spends billions, according to the Government Accountability Office, to fund graduate medical education (GME) residency training for physicians to ensure physician supply and access to care. Medicare GME funding is an entitlement program that is blind to the actual specialty mix of trained physicians. However, research has shown the need for a greater investment in primary care physicians. A 2019 JAMA Internal Medicine study found that every 10 additional primary care physicians per 100,000 population was associated with a 51.5-day increase in life expectancy – an increase that was more than 2.5 times that associated with a similar increase in non-primary care physicians. The inverse is also true and starker: as the density of primary care physicians decreases (11% decline across 10 years), there is a predictable increase in the number of deaths due to preventable causes. The cost of inaction will be an increase in morbidity and higher premature mortality.

The Council on Graduate Medical Education's Twentieth Report noted that effective health care systems have a physician workforce comprised of roughly 50% primary care and 50% subspecialty. The current U.S. physician workforce falls far short of that ideal at 33% primary care. The Institute of Medicine reported that the current Medicare GME program does not produce adequate numbers of physicians prepared to work in needed specialties, geographic areas, or in the community-based settings where most Americans seek care.

Over time, rigid federal GME rules have created barriers to training in rural areas and some community hospitals. The AAFP has identified two bills before the 116th Congress that would help address the problems identified above.

Rural Physician Workforce Production Act (S. 289)

The AAFP urges Senators to cosponsor the bipartisan *Rural Physician Workforce Production Act* (S. 289) sponsored by Sens. Cory Gardner (R-CO), Jon Tester (D-MT) and Cindy Hyde-Smith (R-MS). The bill would provide invaluable new federal support for rural residency training, which will help alleviate physician shortages in those communities. The bill enhances hospitals' ability to pay for rural residency training by establishing an optional National Per Resident Payment in Medicare, to replace existing Medicare GME payment to finance rural training in primary care or any other medical specialty.

The *Rural Physician Workforce Production Act* would provide new financial incentives for rural hospitals (including critical access hospitals) to provide training opportunities needed in the communities they serve. These financial incentives would extend to urban hospitals as well for the specific purpose of growing the number of residents they train in rural areas. The bill is also backed by the Council of Academic Family Medicine, the National Rural Health Association, the American College of

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Osteopathic Family Physicians, the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, and the GME-Initiative.

Advancing Medical Resident Training in Community Hospitals Act (HR 1358)
The AAFP urges Members of Congress to cosponsor the bipartisan *Advancing Medical Resident Training in Community Hospitals Act* (HR 1358) introduced by Reps. Ron Kind (D-WI) and Mike Gallagher (R-WI) which would fund critical new residency programs in communities facing physician shortages, resulting in improved access for patients and increased training opportunities for residents.

Currently, Medicare Direct GME payments are limited based on a formula related to a set per resident amount (PRA) and the capped number of residents (established for most hospitals based on 1996 training levels). Hospitals also have a cap related to Indirect GME payments. Once established, both the Medicare resident cap and PRA are permanent. New teaching hospitals have a one-time opportunity to build a PRA and resident cap. The PRA is set during the first year of training, and the resident cap is built over a five-year period.

The legislation would change CMS GME rules to allow hospitals that trained less than 1 FTE resident in 1996, the base year establishing the resident caps, to establish a new resident cap and PRA. Hospitals that accepted rotations of 3 or fewer FTE residents after October 1, 1997 also would be allowed to establish a new GME cap and PRA. Under this bill, hospitals could accept less than 1 FTE resident rotator without triggering a GME cap and PRA, thereby preserving the opportunity to become a teaching hospital later.

The CMS policy that a GME cap is triggered by any level of training has harmed some hospitals that have accepted casual rotations from other institutions' teaching programs. Hospitals which allowed residents to rotate through inadvertently established a very low FTE cap and a nearly non-existent PRA – even when many impacted hospitals never claimed Medicare payment for the rotators. With low FTE caps and PRAs, those institutions have inadvertently foreclosed their ability to establish the robust residency programs that are now needed in their communities unless Congress acts to address this.

The *Advancing Medical Resident Training in Community Hospitals Act* is also supported by the American Medical Association, the American Association of Colleges of Osteopathic Medicine, the Wisconsin Hospital Association, the Wisconsin Rural Health Cooperative, the Medical College of Wisconsin, and the East Alabama Medical Center.

For more information, contact the American Academy of Family Physicians' Government Relations Department at 202-232-9033.

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Gun Violence Prevention Research

RECOMMENDATION
The American Academy of Family Physicians (AAFP) recommends that Congress address gun violence as a national public health epidemic and appropriate $50 million in fiscal year 2020 to conduct public health research into firearm morbidity and mortality prevention.

Background

According to the U.S. Centers for Disease Control and Prevention (CDC) more people died from firearm injuries in the United States in 2017 than in any other year since at least 1968. Nearly two-thirds were suicides. The AAFP sees gun violence as an epidemic that threatens public health and is urging Congress and the administration both to provide the federal funding needed to support evidence-based research showing the scope of the problem and ensure its public reporting.

Last February, the AAFP was one of more than 160 medical, public health and research groups to contact the Senate and the House to request $50 million in fiscal year 2020 to conduct public health research into firearm morbidity and mortality prevention. The AAFP appreciates that the House Appropriations Committee Labor-HHS-Education fiscal year 2020 funding bill provides $25 million to the Centers for Disease Control and Prevention (CDC) and $25 million to the National Institute of Health (NIH) to research how to prevent firearm injury and death.

The AAFP supports primary prevention strategies to reduce the injuries and deaths associated with gun ownership and violence. The AAFP believes that federal and state policies can balance the right to own firearms with health, safety, and societal well-being. Appropriate gun violence research funding and public health surveillance are essential prevention strategies.

Physicians play an important role in counseling patients about injury prevention, including safe storage practices. Counseling is important for raising awareness for at-risk patients, particularly for child and adolescent patients, and individuals who experience suicidal ideation. In 2015, the AAFP, along with seven other professional organizations including the American Academy of Pediatrics, the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Public Health Association, and the American Bar Association, published a call to action on gun violence in the *Annals of Internal Medicine*. The recommendations included laws to advance gun safety, such as improved background checks and elimination of so-called “gag laws” prohibiting physicians from counseling patients on firearm safety.

Public health research into automobile deaths and injuries played a major role in helping to guide public policy to adopt seat belt and speeding laws. It has also led to advances in motor vehicle technology to ensure modern vehicles are safer to operate. Currently, the limited research into gun violence is uncovering important information that can help prevent mass shootings and other violence. Researchers are learning that there is a connection between domestic violence and those who conduct mass shootings. Also, gun access in the home is associated with higher levels of suicide completion.

The AAFP’s position paper *Prevention of Gun Violence* is available online. *For more information, contact the American Academy of Family Physicians’ Government Relations Department at 202-232-9033.*

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Standard Primary Care Benefit in High Deductible Health Plans

RECOMMENDATION
The American Academy of Family Physicians (AAFP) urges House members to cosponsor the Primary Care Patient Protection Act of 2019 (HR 2774), a bill sponsored by Reps. Brad Schneider (D-IL) and Elise Stefanik (R-NY). The bill would make it more affordable for patients with high deductible health plans to access primary care.

Background

As individuals, families, and employers struggle with the escalating costs of health care coverage, many are seeking high-deductible health plans (HDHP) as a means of securing affordable coverage. In 2017, almost 22 million Americans had enrolled in an HDHP, up from only one million in 2005.[i]

While HDHPs are playing an important role in expanding access to affordable health care coverage, the deductibles associated with the plans are becoming a hurdle to obtaining health care. The Internal Revenue Service defines a HDHP as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family. This high out-of-pocket cost is causing patients to delay seeking care,[ii] extending lapses in health care maintenance,[iii] and decreasing adherence to medication and treatment protocols.[iv]

Family medicine and primary care are foundational to health and wellbeing, as well as a highly-functioning health care system. Patients that have a longitudinal relationship with a family physician and a primary care team tend to have better health outcomes and are better stewards of health care resources. However, the value of primary care to patients and the health care system diminishes when financial or other obstacles are erected.

According to a Centers for Disease Control and Prevention (CDC) report: Financial Barriers to Care: Early Release of Estimates From the National Health Interview Survey, 2016; "Among privately insured adults aged 18–64 with employment-based coverage, those enrolled in an HDHP were more likely than those enrolled in a traditional plan to forgo or delay medical care and to be in a family having problems paying medical bills." Family physicians hear about cost concerns from patients every day. Even if they have health insurance, patients are skipping care because they simply can't afford it, and perhaps more troubling, patients are more worried about paying for care than getting sick.[v]

- About 40% of Americans report skipping a recommended medical test or treatment and 44% say they did not go to a doctor when they were sick or injured in the last year because of cost.
- More people fear the bills that come with a serious illness than the illness itself (40% vs. 33%).

While they are innovative structures that the AAFP supports, HDHPs can compound the cost problem, especially for low-income Americans.[vi] Among low-income individuals with diabetes, for instance, the "skin in the game" created by the HDHP structure appears to discourage appropriate use of health services.[vii] HDHPs should provide more value for the premiums families pay.

The Solution

Under the *Primary Care Patient Protection Act of 2019*, individuals with a HDHP would have access to their primary care physician, or their primary care team, independent of cost-sharing – meaning that the patient could receive primary care services prior to meeting their deductible. The company issuing the HDHP to the

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individual or family would be responsible for providing full coverage of primary care services for the plan year. Primary care is focused on comprehensive, continuous and coordinated care. Primary care services include primary care, prevention and wellness, and care management services (defined by a specific set of billing codes).

Primary care, for the purposes of the legislation, is defined broadly to include the following physician specialties: General Practice; Family Medicine; Internal Medicine; Pediatric Medicine; and Geriatric Medicine. Nurse practitioners are also eligible if allowed by state law.

The California health care marketplace has instituted a similar structure and documented that there was no negative impact on premiums.[viii]

For more information, contact the American Academy of Family Physicians' Government Relations Department at 202-232-9033.

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[i] (See https://www.ahip.org/wp-content/uploads/2018/04/HSA_Report_4.12.18.pdf)

[ii] (See http://news.gallup.com/poll/179774/cost-barrier-americans-medical-care.aspx)

[iii] Ibid.

[iv] Eaddy MT, Cook CL, O'Day K, Burch SP, Cantrell CR. How patient cost-sharing trends affect adherence and outcomes: A literature review. P T. 2012;37(1):45–55. [PMC free article] [PubMed]

[v] (See http://www.westhealth.org/press-release/survey2018/)

[vi] (See https://economics.stanford.edu/events/what-does-deductible-do-impact-cost-sharing-health-care-prices-quantities-and-spending).

[vii] (See http://care.diabetesjournals.org/content/diacare/early/2016/12/09/dc16-1579.full.pdf)

[viii] (See https://www.healthaffairs.org/do/10.1377/hblog20170614.060590/full/)

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Teaching Health Centers

RECOMMENDATION
The American Academy of Family Physicians (AAFP) urges policy makers to reauthorize and fully fund the Teaching Health Center Graduate Medical Education (THCGME) program. Sens. Susan Collins (R-ME) and Jon Tester (D-MT), and Reps. Raul Ruiz (D-CA) and Cathy McMorris Rodgers (R-WA) introduced the *Training the Next Generation of Primary Care Doctors Act of 2019* (S. 1191/ HR 2815). The legislation authorizes the THCGME program for over five years and supports the creation of new programs with a priority for those in rural and underserved communities. The bills would also increase funding from $126.5 million per year (current law) to $141.5 million/year (S.1191) and $151 million/year (HR 2815).

Background

The THCGME program, currently administered by the Health Resources and Services Administration (HRSA), provides funding to increase the number of primary care medical and dental residents training in community-based settings across the country. Since most health care in the U.S. takes place in the outpatient setting, the fundamental goal of the THCGME program is to increase access to well-trained primary care clinicians, particularly in ambulatory settings. It trains residents in seven specialties: family medicine, internal medicine, general pediatrics, geriatrics, obstetrics-gynecology, and psychiatry.

THCGME programs can be located in federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, or other outpatient clinics which operate a primary care residency program. On February 9, 2018, the THCGME program reauthorization was approved within the *Bipartisan Budget Act (HR 1892/PL 115-123)*, until September 30, 2019, at $126.5 million per year.

Action is Needed Now:

Currently, for the 2018-19 academic year, there are 728 residents being trained in 56 HRSA-supported teaching health center (THC) residencies in 23 states and the District of Columbia.[i] Due to funding uncertainty, some programs have slowed down their recruiting or closed over the past few years.

This highly successful and impactful program is set to expire September 30, 2019 unless Congress acts to reauthorize and fund it. The legislation not only reauthorizes the program, it provides enhanced funding and a pathway for increasing the number of residents trained. Most important, the legislation will continue to build the primary care physician pipeline necessary to reduce costs, improve patient care, and support underserved rural and urban communities. This is an important and productive program; it should be funded sustainably. Congress should provide for the Teaching Health Center Graduate Medical Education (THCGME) program immediately to prevent a disruption in the pipeline of primary care physician production.

Benefits of THCs

This program directly addresses three major challenges regarding physician production: (1) the primary care physician shortage, (2) the geographic distribution of medical education, and (3) the number of physicians who serve underserved populations.

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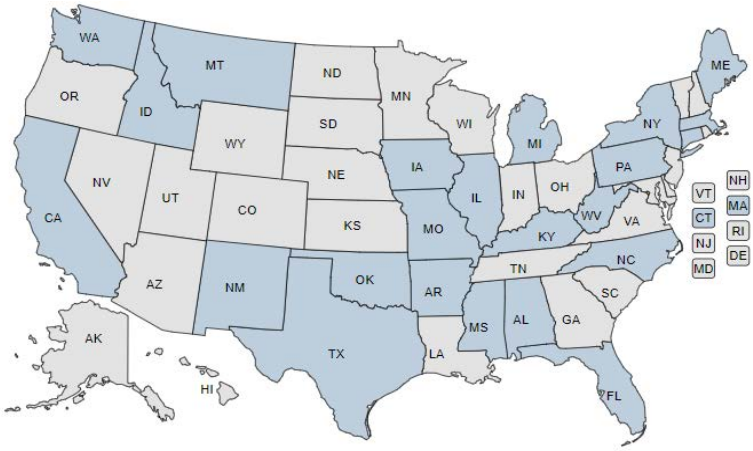
Residents trained in THCs are well prepared for primary care practice in community settings, and data show that training in a medically underserved community (MUC) increases the likelihood that these residents will choose to practice in similar settings upon graduation.[ii] THC graduates are more likely to work in safety net clinics than residents who did not train in these community-based centers.[iii] In addition, research demonstrates that most family physicians practice within 100 miles of their residency program.[iv] The THC program's decentralized training model serves to help remedy the maldistribution of physicians. The program has been successful in increasing access for people who are geographically isolated and economically or medically vulnerable. Additionally, THCGME residency programs meet strict accountability requirements in which every federal dollar is used exclusively for primary care training. These accountability measures can serve as a model for other graduate medical education programs.

Residency Characteristics and Outcomes
According to HRSA's Workforce Analysis based on academic year 2017-2018 data, THCGME programs[v]:

- Produced **880 new primary care physicians and dentists** since the program's inception;
- Retained physicians in primary care at a higher rate than other GME programs (**64% remain in primary care** versus 33% in other GME programs); and
- Increased the number of physicians providing care in an MUC (**58% practice in an MUC and/or rural settings**).



The following are THCGME resident profiles:

- **65% are trained in the specialty of family medicine;**
- 47% received substance use disorder training;
- 40% received training to provide medication-assisted treatment for opioid use disorder care; and
- 82% spent at least part of their training in MUC and/or rural communities.

For more information, contact the American Academy of Family Physicians' Government Relations Department at 202-232-9033.

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[i] Health Resources and Services Administration, Teaching Health Center Graduate Medical Education, website: https://bhw.hrsa.gov/grants/medicine/thcgme
[ii] Ferguson, Warren, Fam Med 2009;41(6):405-10; accessed at: https://fammedarchives.blob.core.windows.net/imagesandpdfs/fmhub/fm2009/June/Warren405.pdf
[iii] Bazemore, Andrew, *Am Fam Physician.* 2015 Nov 15;92(10):868, accessed: https://www.aafp.org/afp/2015/1115/p868.html
[iv] Fagan, Blake, *Am Fam Physician.* 2013 Nov 15;88(10):704, https://www.aafp.org/afp/2013/1115/p704.html
[v] HRSA, Workforce Analysis, 2018-2017, accessed: https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/program-highlights/2018/teaching-health-center-graduate-medical-education-program-2018.pdf