June 24, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

RE: Bipartisan Medicare GME Working Group Draft Proposal Outline and Questions for Consideration

Chairman Wyden and Ranking Member Crapo:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to submit comments on the Senate Finance Committee's ("the Committee") policy outline describing improvements to the Medicare Graduate Medical Education (GME) program to address physician workforce shortages across the country.

SGIM is a member-based medical association of more than 3,300 of the world's leading general internal medicine physicians, who are dedicated to improving access to care for all populations, eliminating health care disparities, and enhancing medical education. Our members are committed to ensuring that all patients have affordable access to the highest quality of care possible. Additionally, we recognize the importance of having a well-trained workforce to achieve these goals.

SGIM is deeply concerned about the country's severe primary care workforce shortages because the healthcare system will never be able to deliver high quality care to all people without having a strong primary care foundation. In nearly all areas of the country, people with serious medical conditions who do not already have a primary care physician cannot get an appointment with a general internal medicine physician who has special expertise in meeting the comprehensive care needs of adults with complex medical conditions or with any other physician who provides primary care services. These shortages are most severe in rural and underserved communities and areas served by safety net hospitals.

According to the Primary Care Collaborative's recent report, in 2019, there were 228,936 primary care physicians, including 91,037 family physicians, 78,984 general internal medicine physicians, and 48,842 general pediatricians.[1] Workforce projections from the Association of American Medical Colleges (AAMC) suggest a shortage of primary care physicians of up to 40,400 by 2036, a number that would be higher if it weren't for recent Congressional investments in Medicare-funded GME.[2] Additionally, projections from the Health Resources and Services Administration (HRSA) National

[1] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf
[2] https://www.aamc.org/media/75236/download?attachment

Center for Health Workforce Analysis project a shortage of 68,020 primary care physicians, including a shortage of 30,080 general internal medicine physicians, by 2036.[3]

SGIM is concerned about these projections and recent research showing that half as many medical residents are choosing a career in general internal medicine compared to 10 years ago.[4] This decline is magnified by a large portion of the primary care physician workforce nearing retirement age[5] and the anticipated healthcare demands as the US population ages. It is important to note that the increasing rates of retirement due to burnout among primary care physicians poses significant concerns. Increasing administrative burden coupled with insufficient reimbursement has pushed some physicians into retirement.[6] As seasoned physicians exit the workforce, the already strained primary care sector faces exacerbated shortages, potentially reducing patient access to care. This highlights the urgent need for increased investment in Medicare GME to train and prepare new primary care physicians.

SGIM appreciates the current federal commitment to improving primary care access. However, despite the federal government's investment to date, the primary care workforce shortage has reached a crisis situation and is still worsening.[7] While there have been calls to bolster the primary care workforce, not enough has been done. We have an urgent need for specific policy changes that can alleviate the current crisis as soon as possible. SGIM was a proud co-sponsor of the National Academies of Sciences, Engineering and Medicine (NASEM) report titled Implementing High Quality Primary Care: Rebuilding Foundation of Health Care. The report highlighted the need for better education, training, and support for the primary care workforce to improve patient access.

The Medicare GME program is a major public funding source that is central to the development of a robust, well-trained workforce. According to a Congressional Budget Office estimate, total federal spending for GME in 2018 was more than $15 billion, of which approximately 80 percent or $12 billion was financed by Medicare.[8] The GME program must be redesigned to achieve long-term stability in the financing of medical training and match medical training with national needs to improve access to and delivery of health care services. As such, we appreciate your consideration of the following comments on the bipartisan Medicare GME working group's proposal and questions for consideration.

Section 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

[3] https://tableau.hrsa.gov/t/BHW/views/WorkforceProjections/SupplyDemandTrend
[4] Paralkar N, LaVine N, Ryan S, et al. Career Plans of Internal Medicine Residents From 2019 to 2021. JAMA Intern Med. 2023;183(10):1166–1167. doi:10.1001/jamainternmed.2023.2873
[5] https://www.aamc.org/data-reports/workforce/data/active-physicians-age-specialty-2021
[6] https://www.definitivehc.com/sites/default/files/resources/pdfs/Addressing-the_healthcare-staffing-shortage.pdf
[7] Rosenthal E. The shrinking number of primary-care physicians is reaching a tipping point. The Washington Post. September 5, 2023. Opinion | The lack of primary-care physicians is reaching a tipping point - The Washington Post.
[8] https://www.cbo.gov/budget-options/54738

SGIM appreciates the investments made by Congress in recent years including the 1,200 new Medicare-supported GME slots authorized by the Consolidated Appropriations Act (CAA), 2021 and CAA, 2023. This was a much-needed investment in Medicare GME and the first increase in the number of slots since 1996. However, Congress must do more to address the critical shortage of primary care physicians, including general internal medicine physicians. Studies continue to show that comprehensive primary care leads to improved health outcomes and reduced health care costs. The aforementioned NASEM report articulates how high-quality primary care is the foundation of the health care system, and without access to comprehensive primary care, acute diseases become chronic, chronic disease management becomes complex, preventive care lags, emergency department visits increase, and health care spending soars.[9]

Therefore, SGIM is pleased to see that this policy outline aims to fund additional Medicare GME slots funded over five fiscal years (FYs 2027 through FY 2031) to address physician workforce shortages. SGIM has a long history of advocating to expand the number of GME slots available and reforming the program to better meet the country's health care needs. In fact, we published a white paper in 2014, which outlined our vision for GME reform to address the nation's physician workforce needs.[10] While this paper is a decade old, it continues to highlight viable options to ensure patients have access to high quality care for generations to come. We recognize that the Committee does not specify the number of additional slots in this draft proposal. However, additional training slots will be essential to meet the growing healthcare needs of our country. As you consider funding a specific number of new Medicare GME slots, SGIM encourages you to take the aforementioned workforce projections into account as well as retirement trends and rates of the country's growing and aging population.

SGIM strongly believes that Congress must ensure that any increase in GME slots include dedicated slots for primary care specialties with well-documented shortages, like internal medicine, family medicine, and pediatrics. Increasing GME slots without specific policy to address shortages will perpetuate the procedure-oriented specialty system we have today and exacerbate the workforce shortages in primary care and other internal medicine subspecialties. Without a directive on specialty distribution, hospitals will have short-term incentives to increase the number of trainees in more lucrative procedural specialties. This will ultimately make the workforce even more unbalanced. Therefore, we appreciate the provision in this section that would require at least 25% of new Medicare GME slots to be allocated toward primary care residencies to address the disproportionate shortage of primary care physicians. However, we strongly recommend increasing this allocation to 50% to more effectively counteract the existing imbalance in the workforce. As the country's population continues to age and we experience a growing prevalence of chronic diseases, Congress must increase funding for Medicare GME funded training positions, particularly for primary care physicians training in internal medicine, family medicine, or pediatrics, to best reflect the physician workforce needs of the nation. By dedicating half of the new GME slots to primary care, we can better ensure a robust pipeline of primary care physicians, ultimately leading to a more balanced and effective healthcare system.

[9] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[10] https://www.sgim.org/File Library/SGIM/Communities/Advocacy/GME-white-paper-2014.pdf

This provision also requires that at least 15% of new Medicare GME slots are distributed toward psychiatry or psychiatry subspecialty residencies to address the disproportionate shortage of psychiatrists. It is important to note that primary care physicians play a significant role in providing mental health care services. A cross-sectional study using Medical Expenditure Panel Survey data found that during the COVID-19 pandemic, primary care physicians provided a significant proportion of care for people with mental health disorders – nearly 40% of visits for depression, anxiety, and any mental illness (AMI) were performed by primary care physicians.[11] Primary care physicians also provided over one-third of the care and wrote a quarter of the prescribed medications for patients with severe mental illness.

SGIM recognizes that this proposal would maintain other aspects of the GME allocation formula enacted in the CAA, 2023. Previous distribution methodologies used by the Centers for Medicare & Medicaid Services have awarded residency positions to qualifying hospitals based on the Health Professional Shortage Area (HPSA) score of the area served by the residency program with those programs serving areas with higher HPSA scores receiving higher prioritization. We encourage the distribution of GME slots to primary care and recommend that the remaining slots be distributed by HPSA score. This will ensure an appropriate number of the new residency positions will go to the hospitals where they will have the greatest impact on access to care—where there are well-documented shortages in primary care and other internal medicine subspecialties. This HPSA-based approach will not only address the current maldistribution of the physician workforce and mitigate workforce shortages in primary care, including general internal medicine, but also address help to reach underserved populations.

Furthermore, SGIM appreciates the provision under this section which would direct the Secretary of the Department of Health and Human Services (HHS) to prioritize new Medicare GME slots for hospitals committed to training physicians who are more likely to work in a rural or underserved community long-term. By prioritizing GME slots for institutions focused on underserved communities, the provision ensures physicians will be trained to serve in these areas.

Section 3. Encouraging Hospitals to Train Physicians in Rural Areas

SGIM believes that recruitment and retention of primary care physicians is crucial in addressing the crisis in healthcare access in rural areas. The Milbank Memorial Fund's *2024 Primary Care Scorecard* found that fewer than 5% of primary care residents spent a majority of their training with the most underserved communities in the United States, highlighting a gap in the distribution of training.[12] Therefore, SGIM supports the Committee's proposal to allow sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs) serving rural communities to receive indirect medical education payments in addition to the Medicare direct GME payments they receive. This will not only encourage hospitals to train physicians in rural areas and help them

[11]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/#:~:text=Using%20MEPS%20data%2C%20we%20showed,are%20to%20primary%20care%20physicians

[12] Jabbarpour Y, Jetty A, Byun H, Siddiqi A, Petterson S, Park J. The Health of US Primary Care: 2024 Scorecard Report — No One Can See You Now. The Milbank Memorial Fund and The Physicians Foundation. February 28, 2024.

manage the costs associated with training residents, but also improve healthcare access, quality, and outcomes in underserved rural areas.

Additionally, this section would extend the ability of teaching physicians to use telehealth to supervise resident physicians beyond December 31, 2024. Our members, many of whom serve as the primary internal medicine faculty of medical schools and teaching hospitals throughout the United States, have found that teaching models continue to incorporate remote supervision into practice. This flexibility has been invaluable to SGIM members and our patients. This flexibility facilitates care when a teaching physician can only provide remote supervision for any of a range of reasons. Additionally, large hospitals or academic medical centers located in urban areas often establish affiliated hospitals in rural areas to extend their reach and provide healthcare services to underserved populations. Therefore, remote supervision will continue to sustain clinical capacity as many teaching sites deliver care to vulnerable populations. By better enabling physicians to deliver care from where they are, patients will be better able to receive care in their communities. We believe this flexibility is another important tool to expand access to care, particularly in shortage specialties like general internal medicine. For these reasons, we urge the Committee to make this flexibility permanent.

Section 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

This provision would direct the HHS Secretary to establish a time-limited GME Policy Council (the "Council") consisting of 9 members representing academic medical institutions, hospitals that serve rural areas and underserved communities, medical students, and health care workforce experts. The Council will be required to evaluate the distribution of new Medicare GME slots made available under this bill and make recommendations to the Secretary regarding the distribution of the new Medicare GME slots added by this bill. SGIM supports this proposal as we believe this represents an evidence-based approach to ensuring strategic distribution of the slots made available through this legislation. A time-limited Council will work to address our nation's severe physician workforce shortage and ensure that new Medicare GME slots are meaningfully distributed.

As you consider the composition of the Council, SGIM recommends that you include health economists. The inclusion of health economists and other experts in healthcare workforce policy will bring valuable insights into the evolving needs of the healthcare system, guiding effective and sustainable solutions for workforce planning. Moreover, to further enhance the Council's effectiveness, we recommend that the Council work closely with HRSA's Council on Graduate Medical Education (COGME) to ensure a smooth coordination and integration of recommendations into existing GME policies. Leveraging COGME's expertise and experience in workforce planning and policy development will ensure the most strategic distribution of new Medicare GME slots.

Furthermore, SGIM supports a GME system that produces a workforce of appropriate size, specialty mix, and geographic distribution to meet regional and national workforce needs. We believe that decisions affecting the allocation of GME positions must be based on accurate data from unbiased sources that assess current and predict future healthcare needs. Therefore, this

Committee should consider expanding the charge of this Council to assess GME policy beyond that authorized by this proposal to develop recommendations for healthcare workforce policy using data to assess the healthcare workforce supply and develop a long-term strategy to support an appropriately distributed workforce.

Section 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

The CAA, 2021 gives certain hospitals 5 years to build up their residency programs so they can reset their low GME caps and expand the number of residents they train. In response to stakeholder concerns that hospitals need more time to build up residency programs, this provision would amend the CAA, 2021 by extending the time for eligible hospitals to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap from 5 years to 10 years. SGIM supports this proposal as it will give hospitals more time to develop primary care residency programs and adjust their GME caps, which were put in place to limit the number of residency positions that Medicare will fund. This extension will not only facilitate the expansion of residency programs, but also address the ongoing primary care physician shortage. However, it is crucial that this flexibility is not abused and only used by the hospitals where establishing a program within 5 years would be exceptionally challenging. Hospitals should be encouraged to build their residency programs expeditiously and we believe there are very few instances where a hospital would take 10 years to build up a program.

Section 6. Improvements to the Distribution of Resident Slots Under the Medicare Program after a Hospital Closes

This provision amends the distribution process for GME slots from closed hospitals' residency programs. While it maintains the requirement to prioritize hospitals in the same core-based statistical area and state, it removes the priority for hospitals in the same region, broadening the distribution reach. Additionally, under this provision, hospitals must show they can use these positions within 2 years and fill them within 5 years. SGIM supports this provision which intends to make GME slots more accessible to hospitals across a broader geographic area while ensuring that these positions are effectively used and filled within a specific timeframe. We believe that it is more important to give priority to areas in greatest need, rather than to a particular region. These two factors combined will optimize physician training and healthcare delivery.

Section 7. Improving GME Data Collection and Transparency

This provision aims to address the lack of accountability and transparency in the Medicare GME program by requiring the Secretary of HHS, in consultation with the Secretary of the Department of Veterans Affairs, to submit an annual report to Congress and create a public database on federal GME programs and requiring teaching hospitals to report specific information including resident demographics, Medicare GME payments, and the outcomes of residency programs. Additionally, this provision requires HHS to analyze and assess how Medicare GME investments address projected shortages by state, using existing data to minimize administrative and reporting burdens.

SGIM strongly believes that GME dollars must be spent transparently and exclusively for resident training and related costs. GME funds flow directly to the sponsoring institutions with little public accountability for training outcomes. Funds should be used exclusively to support training, not to subsidize other activities of hospital costs. Additionally, residency program directors, responsible for training outcomes, have limited knowledge of their hospital GME financing and little input into how funds flow to support training in their institution. Therefore, we support this provision which would require teaching hospitals to report specific data related to their GME residents, programs, and payments. This provision will enhance transparency and accountability in the Medicare GME programs and provide a better understanding of GME funding and inform policy makers and identify gaps or areas in need of more funding and support, leading to more equitable and effective allocation of resources.

Thank you for the opportunity to provide these comments. SGIM is committed to working with you to address primary care physician shortages and protect patient access to care for generations to come. Should you have any questions, please contact Michaela Hollis at mhollis@dc-crd.com.

Sincerely,

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