January 31, 2025

The Honorable Bill Cassidy, M.D.
455 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
Washington, DC 20510

The Honorable Catherine Cortez Masto
520 Hart Senate Office Building
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Building
Washington, DC 20510

Re: Draft Medicare GME Reform Package

Dear Senators Cassidy, Cornyn, Cortez Masto, and Bennet,

The Society of General Internal Medicine (SGIM) appreciates the opportunity to comment on your draft legislation to improve the Medicare Graduate Medical Education (GME) program. We applaud your efforts to increase the nation's supply of physicians and meet the growing needs of communities 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 delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care. Additionally, we recognize the importance of having a well-trained workforce to achieve these goals.

SGIM is deeply concerned about the country's primary care workforce shortage because the healthcare system will never be able to improve Americans' health and reduce the health and economic burdens of chronic diseases without a strong primary care foundation. Across the country, approximately 29% of adults do not have access to a usual source of primary care.[1] In nearly all areas of the country, we are hearing more often from people with serious medical conditions who do not have a primary care physician and who cannot get an appointment with a general internal medicine physician who has special expertise in meeting the comprehensive care needs of adults. The lucky ones who can make an appointment often have to wait many months for the next available opening. These shortages are the most severe in rural and underserved communities.

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

[1] https://www.milbank.org/primary-care-scorecard/

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internal medicine physicians, and 48,842 general pediatricians.[2] The National Center for Health Workforce Analysis projects a shortage of 87,150 primary care physicians in 2037, including a shortage of 28,890 general internal medicine physicians.[3] Data and research show that half as many medical residents are choosing a career in general internal medicine compared to 10 years ago.[4] This decline is exacerbated by a large portion of the primary care physician workforce nearing retirement age[5] and the growing health care demands as the country's population ages. Additionally, retirement rates due to burnout among primary care physicians are increasing and pose significant concerns. Increasing administrative burden coupled with insufficient reimbursement has pushed some physicians into early retirement.[6] SGIM recognizes the supportive role advanced practice providers (APPs) play in meeting the country's health care needs and their ability to expand access to care; however, APPs are not a substitute for the skills provided by primary care physicians, particularly in caring for patients with multiple and complex chronic conditions. **This predicted shortage highlights the urgent need for increased investment in Medicare GME to train and prepare new primary care physicians.**

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.[7] **The GME program must be redesigned to achieve long-term stability in the financing of medical training and align the supply of physicians in various specialties with national needs, including addressing shortages in primary care, to improve access to and delivery of health care services.**

For these reasons, we thank you for releasing this draft legislation and appreciate your consideration of the following comments.

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

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

[2] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/PrimaryCareChartbook2021.pdf
[3] https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand
[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] https://www.cbo.gov/budget-options/54738

in Medicare GME and the first increase in the number of slots since 1996. Yet, studies continue to show that comprehensive primary care leads to improved health outcomes and reduced health care costs. The National Academies of Sciences, Engineering and Medicine (NASEM) report titled "Implementing High Quality Primary Care: Rebuilding Foundation of Health Care" articulates how high-quality primary care is the foundation of the healthcare system, and without access to comprehensive primary care, acute diseases become chronic, chronic disease management becomes more complex, preventive care is neglected, emergency department visits increase, and health care spending soars.[8] **Therefore, SGIM is pleased to see that this draft legislation would fund 5,000 additional Medicare GME slots over five fiscal years (FYs 2027 through 2031) to address physician workforce shortages.**

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, those specialties focused on keeping people healthy and preventing chronic conditions from turning into acute episodes. Without a directive on specialty distribution, hospitals will have short-term incentives to increase the number of trainees in more lucrative procedural specialties leaving 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.** 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.

SGIM recognizes that at least 15% of the new slots would also go towards psychiatry or psychiatry subspecialties. It is important to note that primary care physicians play a significant role in providing mental health care services to patients. Some research suggests that up to 75% of primary care visits include mental or behavioral health care,[9] including, but not limited to, visits for depression, anxiety, ADHD, and substance

[8] 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.

[9]https://www.aafp.org/pubs/fpm/issues/2021/0500/p3.html#:~:text=Up%20to%2075%25%20of%20primary,diet%2C%20and%20exercise%20on%20health.

abuse.[10,11] Other research shows that primary care physicians also play extensive roles in managing medications for individuals with mental illness with primary care physicians prescribing at least 50% of medications in urban areas and over 70% in rural areas.[12] **Therefore, by increasing slots allotted to primary care specialties, Congress would not only address the critical shortages in primary care but also help alleviate the demand for mental health services.**

Section 3. Encouraging Hospitals to Train in Rural Areas

To support rural hospitals in building residency training infrastructure, the draft legislation would allow Sole Community Hospitals (SCHs) and Medicare-Dependent Hospitals (MDHs) to receive IME payments, in addition to the Medicare direct GME payments they receive, to support the cost of training residents 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.[13] **Therefore, SGIM supports this provision as it will encourage hospitals to train physicians in rural areas and help them manage the costs associated with training residents, as well as improve healthcare access, quality, and outcomes in underserved and rural areas.**

Additionally, this section would extend the use of real-time audio and video technology for teaching physicians to supervise residents via telehealth beyond January 1, 2026. **SGIM urges you to finalize this provision to make this telehealth flexibility permanent.** 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 facilitates care when a teaching physician can only provide remote supervision for any of a range of reasons and has been invaluable to SGIM members and our patients. Additionally, large hospitals or academic medical centers located in urban areas often establish affiliated hospitals in rural areas to extend their reach and provide health care services to underserved populations. Therefore, remote supervision will continue to sustain clinical capacity as many teaching sites deliver

[10]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8202306/#:~:text=Using%20MEPS%20data%2C%20we%20showed,are%20to%20primary%20care%20physicians
[11]https://pmc.ncbi.nlm.nih.gov/articles/PMC2925161/#:~:text=Some%20research%20has%20suggested%20that,of%20by%20mental%20health%20providers.
[12]https://pmc.ncbi.nlm.nih.gov/articles/PMC9706942/#:~:text=In%20urban%20areas%2C%20PCPs%20prescribed,%2D022%2D08813%2D6.
[13] 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.

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.

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

The draft legislation would create a new Medicare GME Policy Council (the "Council") consisting of 13 members representing academic medical institutions (including at least one representative of an allopathic medical school and one representative of an osteopathic medical school), hospitals servicing rural and underserved areas, medical students, healthcare workforce experts, and at least one doctor of medicine and at least one doctor of osteopathy.

SGIM supports the authorization of the Council and its composition; however, we recommend that you include at least one health economist on the Council. 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, it is our understanding that the Council's functions are to:

- Advise the Secretary of HHS every five years, starting in fiscal year 2032, on the allocation of GME positions based on geographic and specialty physician shortages.
- Evaluate the distribution of GME positions to ensure compliance with requirements and effectiveness in addressing projected physician shortages, particularly in rural and medically underserved areas.
- Develop a measure to assess how many physicians trained in approved residency programs practice in health professional shortage areas (HPSAs) or medically underserved areas, and for how long.
- Advise on the application process for hospitals with low resident limits to access remaining GME positions after fiscal year 2031.
- Collaborate with the Accreditation Council on Graduate Medical Education (ACGME).

SGIM is pleased to see a comprehensive charge for the Council, particularly the directive to evaluate the distribution of GME positions in addressing projected workforce shortages. We also appreciate the directive to develop a measure to assess

how many physicians trained in approved residency programs practice in HPSAs or medically underserved areas, and for how long.

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, we encourage you to expand the charge of the Council to develop recommendations for healthcare workforce policy, including a long-term strategy to support an appropriately distributed workforce.** This should include a comprehensive review of current and projected healthcare workforce supply and demand, an evaluation of existing federal training programs, including Medicare GME, an analysis of effective financing mechanisms for healthcare education and careers, and the development of recommendations to eliminate barriers to physician recruitment and retention. SGIM believes this is critical as there is currently no overall assessment of the specialty or geographic distribution of the physician workforce to optimally meet the healthcare needs of the US population.

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

The CAA, 2021 gives certain hospitals five 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, the draft legislation would amend the CAA, 2021 to provide these hospitals with an unlimited amount of time to establish a new per resident amount (PRA) or residency full-time equivalent cap. **SGIM appreciates this proposal; however, we believe increasing the timeframe from five years to 10 years is more appropriate.** Hospitals should be encouraged to start making changes within five years, but reaching their full targeted training capacity may reasonably take up to 10 years. This approach will still 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.

Section 6. Improvements to the Distribution of Resident Slots under the Medicare Program After a Hospital Closes

The draft legislation would amend 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

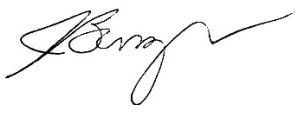
hospitals in the same region, broadening the distribution reach. Additionally, under this provision, hospitals must show they can use these positions within 2 years and fill them within 5 years. **SGIM supports this provision which intends to make GME slots more accessible to hospitals across a broader 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 health care delivery.

Section 7. Improving GME Data Collection and Transparency

The draft legislation would direct the Centers for Medicare & Medicaid Services (CMS) to publicly report information on federal GME programs and publish this information in a public use data file that is easy to use by researchers, policymakers, and the public. **SGIM believes that GME dollars must be spent transparently and exclusively for resident training and related costs.** It's important to note that Medicare GME funds flow directly to sponsoring institutions with little public accountability for training outcomes. These 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. This is a significant gap in transparency and undermines the effectiveness of Medicare GME funding. **Therefore, SGIM strongly supports this provision which will enhance transparency and accountability in the Medicare GME program 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 your consideration of this feedback! We welcome the opportunity to discuss our comments with you further. Should you have any questions, please contact Michaela Hollis at mhollis@dc-crd.com.

Sincerely,



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