Recommendation:
We request Members and/or Senators cosponsor:

S. 304, *Training the Next Generation of Primary Care Doctors Act of 2019*
S. 289, *Rural Physician Workforce Production Act of 2019,* and
HR 1358*, Advancing Medical Resident Training in Community Hospitals Act of 2019*

About the GME Initiative (GMEI):
The GME Initiative's purpose is to improve the health of rural and urban underserved communities by identifying and supporting reforms to the funding of graduate medical education to ensure the production of the clinical workforce needed to serve patients of our diverse communities. It is a grassroots volunteer group of approximately 150 members residing in roughly 35 states. The GMEI includes health care leaders, educators, advocates, and learners passionate about reforming Graduate Medical Education (GME) through partnerships, state initiatives, education, and advocacy.

The Problem:
Family medicine and primary care saves money and lives, yet the nation's production of such physicians – urban and rural - is hampered by antiquated Medicare rules. Family Physicians and other specialty physicians (e.g. General Surgeons, Psychiatrists, Obstetricians) are in critical shortage in rural communities. The maldistribution of the physician workforce, both geographically and in terms of specialty, has many causes, but a major factor is the current structure of the Medicare graduate medical education funding system.

Under current law, the federal government supports medical residency training, i.e. graduate medical education (GME), 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. Over time federal GME support has created barriers to funding training in rural areas. Rural America is experiencing a physician workforce crisis and rural hospitals are closing for lack of physician services. Rural physicians are approaching retirement in high numbers and few graduates are relocating to replace them. Research shows the greatest indicator of where a physician will practice is the location of their residency training – hence the need to train more physicians in these areas.

Current funding mechanisms for residency training in rural areas provide inadequate resources. These hospitals receive a disproportionately smaller amount of funding due to the methodology that Medicare uses to fund GME training, such that existing programs are often vulnerable to closure, successful programs can't expand, and new programs are difficult to create. For people seeking care in certain regions, access is limited because the essential resources needed to increase production of physicians in those areas are limited.

Legislation to Cosponsor:
The GMEI has identified three current bills in Congress that would help address the problem identified above and which we are asking Members and/or Senators to cosponsor.

Teaching Health Center Graduate Medical Education (GME): Please cosponsor S. 304,*Training the Next Generation of Primary Care Doctors Act of 2019,* which reauthorizes the Teaching Health Center program for five years, increases funding for current programs (to account for rising costs of training since the program was first launched), and includes funding increases for the development of new programs/centers. The THCGME Program, established in 2010 and reauthorized in 2015 and 2018 has been, by any measure, an overwhelming success. In the 2017-2018 academic year, the program supported the training of 732 residents in 57 primary care residency programs, across 24 states. Since

Mannat Singh, Director of GMEI | mannat.singh@gmail.com

2011, the program has supported the training of over 630 new primary care physicians and dentists that have graduated and entered the workforce. Importantly, physicians trained in teaching health center programs are more likely to practice in rural and other underserved communities, increasing access to care for the country's most vulnerable patient populations. We commend bill sponsors – Senators Collins (R-Maine), Tester (D-Montana), Moore Capito (R-West Virginia) Jones (D-Alabama), Boozman (R-Arkansas), Manchin (D- West Virginia), and Harris (D-California).

Rural GME: Please cosponsor S. 289, *Rural Physician Workforce Production Act of 2019.* Introduced by Senators Gardner (R-CO), Tester (D-MT), and Hyde-Smith (R-MS) this bill addresses many of the problems inherent in the Medicare GME system that have limited growth and expansion of training in rural areas and have been prime factors in our nation's geographic maldistribution of physicians. Of key importance, it addresses the problem of lower resources for rural training by establishing an alternate payment for training residents that is more in keeping with actual training costs. It also addresses many of the cap and other payment limitations that have been barriers to rural training. The bill is backed by the GME Initiative, Council of Academic Family Medicine, American Academy of Family Physicians, National Rural Health Association, American College of Osteopathic Family Physicians and the American Association of Colleges of Osteopathic Medicine.

Rotator Legislation: Please cosponsor *HR 1358, Advancing Medical Resident Training in Community Hospitals Act of 2019.* Representatives Ron Kind (D-WI) and Mike Gallagher (R-WI) along with the entire Wisconsin delegation from the House of Representatives, introduced legislation to provide for a fix for what we call the Rotator problem. Many hospitals have experienced a problem of finding the Centers for Medicare and Medicaid Services (CMS) has determined that they are a teaching hospital, even though they have never had a teaching program. Hospitals that took individual residents for "away" rotations, even very briefly, are finding out that CMS has set a cap, and often a miniscule PRA, both of which are so low that it is impossible to start a program in that location. Additionally, some community hospitals are afraid to take residents from another hospital or program for a rotation because that might start the cap-setting process because they want to preserve their ability to become a teaching hospital in the future. The legislation would allow for a "redo" of cap and PRA setting for hospitals who had less than 1 FTE rotate through in the 1996 cap-setting year, and/or less than 3 FTE for hospitals in the time since 1996 and the date the bill is enacted, and it would also allow hospitals to continue to accept less than 1 FTE per year into the future without starting the cap setting clock, or establishing a PRA. This has strong implications for rural GME, as well as hospitals in non-rural areas. National organizations such as the American Association of Medical Colleges (AAMC), the Council of Academic Family Medicine, and the AAFP, as well as numerous hospitals and hospital systems support this bill.

Guiding Principles of GME Reform:
As the GME Initiative examines draft legislation, it is guided by several principles, noted below, which recognize the priority of addressing primary care payment reform and workforce enhancement needs in our rural and underserved communities, as well as, the critical changes in other aspects of the system required to generate a robust primary care workforce.

- Meet the needs of the Nation – provide a workforce that serves patients and communities.
- Train the right specialty mix of physicians who will practice where they are needed.
- Produce enough primary care physicians to achieve a minimum of 40% of the total physician workforce.
- Accurately measure primary care production.
- Provide funding that is predictable, long-term and sustainable.
- Support existing primary care residencies and all specialty training in rural locations.
- Increase the number of training positions in primary care.
- Correct geographic maldistribution of GME payments among states.
- Incentivize students to pursue training and practice location goals attuned to America's needs.
- Correct primary care reimbursement differential.