AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

June 24, 2024

The Honorable Ron Wyden
Chair
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

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

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

The Honorable Bill Cassidy, MD
Senate Finance Committee
455 Dirksen Senate Office Building
Washington, DC 20510

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

The Honorable Thom Tillis
Senate Finance Committee
113 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Bob Menendez
Senate Finance Committee
528 Hart Senate Office Building
Washington, DC 20510

The Honorable Marsha Blackburn
Senate Finance Committee
355 Dirksen Senate Office Building
Washington, DC 20510

Re: Bipartisan Finance Members Outline Proposal to Improve Medicare Physician Training to Reduce Workforce Shortages

Dear Senators Wyden, Cornyn, Bennet, Cortez Masto, Menendez, Cassidy, Tillis, and Blackburn:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to comment on the Senate Finance Committee's draft policy proposal and specific questions for consideration on policies related to the Medicare Graduate Medical Education (GME) program. As the largest professional association for physicians and the umbrella organization for state and national medical specialty societies, the AMA is committed to ensuring that there is proper access to physicians for all patients and that physicians are well supported in their role as leader of the health care team. If workforce barriers for physicians are reduced, and additional investments in GME are made, it will help to increase the number of physicians in the U.S., which will lead to healthier communities and ultimately a healthier country as access to much-needed medical care increases.

How many additional Medicare GME slots are needed to address the projected shortage of physicians?

In 1996, Congress decided to restrict what it would contribute to physician residencies through limits on the number of resident full-time equivalents (FTEs) and per resident amounts (PRAs) it would support via the Balanced Budget Act of 1997. As a result, the FTEs that Medicare GME payments support are capped

at the number of FTE residents that hospitals reported training in their 1996 Medicare cost reports. Moreover, both Direct GME (DGME) and Indirect GME (IME) payments are subject to this hospital-specific cap. This has led to increased physician shortages across the country that impact certain geographic regions more than others because although the population and the geographic spread of where people in the United States live has changed over the past 30 years, the cap remains mostly inflexible.

Regrettably, according to the Health Resources and Services Administration (HRSA), over 19,000 providers are currently needed just to eliminate our primary care and mental Health Professional Shortage Areas (HPSAs). On a larger scale there is a projected shortage of 86,000 physicians by 2036. Unfortunately, due to the cap and its rigid standards, residency positions have not been able to adapt and change as needed with our population and the cap has led to the physician shortages we are currently experiencing.

To begin remedying this shortage, the cap should be removed and instead there should be consistent flexible increases in Medicare GME funding that will help to negate our current shortages while not recreating the current problems that exist with the cap today. Additionally, we appreciate the phase-in approach to increasing the cap that is currently being utilized by the additional 1,200 new Medicare supported GME positions that were created through the 2021 and the 2023 Consolidated Appropriations Acts. We believe this metered approach to adding new slots will allow time for teaching programs to adjust and expand to provide education to additional residents. Moreover, we would encourage Congress to enforce these phase-in requirements that were laid out in the Consolidated Appropriations Acts (CAA) for the current distribution of the 1,200 new slots.

To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?

The AMA recognizes that there are shortages of primary care physicians and psychiatrists that currently exist and understands the desire to cultivate more physicians in these specialty areas. However, we do not believe that slots should be specialty-specific. Instead, slots should be able to go to the specialty that is in need or desired by the area. Moreover, we are concerned that by highlighting certain specialties over others it could lead to future shortages in those specialties that are not currently prioritized.

Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities?

Though the AMA supports including hospitals located in a rural area, hospitals located in an area with a rural-urban commuting code equal to or greater than 4.0, sole community hospitals, and hospitals located within 10 miles of a sole community hospital, we do not support excluding hospitals that are treated as being located in a rural area from the definition of rural hospitals.

To receive more slots under the current CAA provisions a teaching hospital must be training at the top of, or over, their current cap and have a high HPSA score relative to the other applicants. However, there are only approximately 82 rural teaching hospitals in the U.S. and of those, only 43 are currently training over their cap. As such, there are only a few rural teaching hospitals that would even begin to qualify for these additional slots.

Moreover, the stakes for new teaching hospitals and hospitals that start new programs are extraordinarily high. The cost of developing new programs is considerable and completely borne by the institutions since Medicare does not reimburse hospitals for these start-up costs, and hospitals do not receive reimbursement until residents rotate to the hospital. For example, "[h]ospitals starting their first GME training program spend an estimated $2 million to $8 million over three to seven years to establish GME programs, according to information from hospital representatives." With this level of upfront costs, it is understandable that these small rural facilities may choose to not apply. Federal policymakers should recognize that the combination of the residency cap and lack of resources, rather than some inherent bias, are the primary reasons behind hospitals in rural areas having difficulty increasing the total number of GME slots or creating new residency programs. Therefore, the definition of rural hospital should be expanded, not narrowed, so that the maximum number of hospitals serving rural communities can qualify and apply for these additional slots.

How could Congress improve the recruitment of physicians to work in rural or underserved communities?

In order to help curtail the current and projected shortage more rural residency positions should be created. "Residents often continue to practice in locations where they complete GME training, which ultimately influences the distribution of the health care workforce. A 2020 study found that 56 percent of the residents who completed their training between 2010 and 2019 were still practicing in the state in which they trained at the end of 2019, and a 2015 study found that a similar portion of family medicine residents practiced within 100 miles of their training site after completing their training. Unfortunately, the physicians who are most likely to practice in rural regions, such as those graduating from medical schools in rural areas, declined by 28 percent between 2002 and 2017. This decrease is compounded by the fact that in 2016 and 2017 only 4.3 percent of incoming medical students were from rural backgrounds.

In addition to the program improvements noted, holistic changes to the rural physician working environment need to be made. Students need to be recruited earlier in life. Additionally, communities that need health professionals should be educated about medical education and encouraged to help groom and assist local students with getting into medical school. Moreover, pathway programs, including but not limited to the Pathways to Practice Model included in the Build Back Better legislative proposal, and holistic outreach (mentors, interview prep, etc.) are necessary. Medical schools and residency programs should develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements and provide early and continuing exposure to those programs for medical

students and residents. Finally, once individuals choose residencies in rural areas, support systems are needed.

Teaching Health Center Graduate Medical Education (THCGME)

"Recruitment and retention of health professionals has long been a persistent challenge for rural providers." Only about one-third of hospitals located in rural areas are training over their Medicare GME caps. To try and bolster the number of providers in rural communities the THCGME program was created. "The primary goal of the THCGME Program is to increase the number of primary care physician and dental residents training in community-based ambulatory patient care settings. The training opportunities created for THCGME-supported residents build the workforce and improve the distribution of the nation's primary care workforce in economically disadvantaged areas, through an emphasis on rural and other underserved communities and populations. Teaching Health Centers are located predominantly (80 percent) in community-based health centers, such as Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, Rural Health Clinics, and Tribal Health Centers that provide primary care services in underserved areas. In Academic Year 2016-2017, the majority of THCGME residents (83 percent) spent part of their training in medically underserved and/or rural communities, and these residents provided more than 795,000 hours of patient care." Since there are so many positive benefits to THCGME this program should be expanded. One form of expansion would be to increase funding for THCGME since this would help to create more residency training slots and thus would increase the overall pool of physicians.

Loan Repayment and Scholarship Programs

The AMA believes that the cost of medical education should never be a barrier to the pursuit of a career in medicine. However, medical education remains the most expensive post-secondary education in the United States. Nearly 75 percent of medical school graduates have outstanding medical school debt, with the median amount being $200,000. This number will only continue to significantly increase as the cost of medical school continues to rise. In fact, for first year students in 2020-2021, the average cost of attendance increased from the prior year for public medical schools by 10.3 percent, making it likely that medical students will have to carry even larger student loans in the future in order to graduate.

In general, reducing medical student indebtedness promotes diversity within medicine and may lead to an increase in the primary care physician workforce as well as other undersupplied specialties. Rising medical school debt disproportionately impacts students who are low income. Due to the cost of medical school many low-income individuals are completely deterred from attending medical school in the first place.

According to a national survey, the cost of attending medical school was the number one reason why qualified applicants chose not to apply. Additional surveys by the Association of American Medical Colleges (AAMC) support this conclusion and found that underrepresented minorities cited cost of attendance as the top deterrent to applying to medical school. Since minority students are more likely to

enter primary care than their White counterparts, the immense debt burden of medical school has not only precluded diversity among physicians, but also has limited the potential number of primary care physicians and thus diminished improvement in patient care in underserved communities. With recent health reforms seeking to eliminate health care disparities among the U.S. population, increasing the number of historically underrepresented physicians is important to ensure a health care workforce that is more reflective of the general population. As such, the immense debt burden experienced by America's physician workforce must be remedied and one important tool to do that is to provide more scholarships and loan repayment programs through the federal government.

Thankfully, Congress can take immediate action to help curtail some of the negative effects of medical school debt. Congress should immediately pass H.R. 1202/S. 704, the "Resident Education Deferred Interest (REDI) Act," bipartisan legislation that permits borrowers in medical or dental internships or residency programs to defer their student loans until completion of their educational training.

National Health Service Corps (NHSC)

HPSAs are used to identify areas, populations, groups, or facilities within the U.S. that are experiencing a shortage of health care professionals. There are more than 8,300 federally-designated HPSAs where dire access issues persist for patients in both rural and urban underserved communities, and in both primary and specialty care. With the existing and projected physician shortage, and the increased demands that have been placed on physicians during the COVID-19 pandemic, additional support for programs like the NHSC is desperately needed.

The NHSC provides scholarships and loan repayment options for health care providers who are willing to serve in HPSAs for a designated period of time. The NHSC has three loan repayment programs: the NHSC Loan Repayment Program, the NHSC Substance Use Disorder Workforce Loan Repayment Program, and the NHSC Rural Community Loan Repayment Program. The NHSC also has a scholarship program. Physicians are eligible for all of these programs, though each program has a different service commitment and amount that can be forgiven.

Physicians seeking repayment through these programs must be a provider (or be eligible to participate as a provider) in Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate and must have qualifying loans.

The NHSC Scholarship Program (NHSC SP) "awards scholarships to students pursuing eligible primary care health professions training." However, only "four percent of providers ha[ve] received NHSC funding during their time in school through the NHSC Scholarship Program." As such, this program has the highest proportional rejection rate at 89 percent. Since scholarships help to diminish the financial burden of medical school from the outset, which promotes greater diversity in applicants, and ultimately a greater diversity in the physician workforce, additional funding should be provided to bolster the scholarship aspect of the NHSC program.

Furthermore, "[i]n fiscal year 2020, 43 percent of the 11,102 providers who newly applied to NHSC programs did not receive funding" and physicians were among the providers with the highest proportions of rejected applicants. This is in part because "HRSA prioritizes funding to providers serving in HPSAs with more severe provider shortages..." However, 40 percent of rejected applicants were providing care at sites with HPSA scores that were in the upper half of possible scores. Also, 33 percent of HPSA sites had vacancies for primary care physicians, demonstrating the continued need for more physicians. It has been shown that with additional federal funds more providers are hired, and thus more care can be provided.

If additional NHSC funding was available, applications from physicians working at care sites that are in the upper half of HPSA scores would be the next to receive funding from HRSA. The NHSC program, both scholarship and loan repayment, are extremely beneficial for physicians and for the communities they serve since they increase health centers' care capacity.

In addition to providing additional funding, the NHSC program should provide intensive and frequent counseling to NHSC scholars as they enter and then proceed through the NHSC program. Through briefings, as well as frequent written communications, the NHSC administrators should emphasize the dynamic nature of the HPSA Placement Opportunity List and the possibility of changes in placement options at any time. Counseling should highlight the extent of any financial commitments that a scholar may have to incur to develop a Private Practice Option opportunity and the future possibilities of obtaining a Private Practice Option and/or a federal placement. Moreover, the NHSC program should try not to impose changes in assignment options during the last year of the obliger's education, to avoid disruption of any personal and family plans of the physician applicants.

Finally, the NHSC should be expanded to include more scholarships, greater loan forgiveness, and the inclusion of all medical specialties in need. When programs are added, such as the Maternity Care Target Area, additional resources should be expended to ensure that physicians know about these additional care pathways. The NHSC program should also be expanded to include service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas. By adding more programs and specialties to the NHSC, better care will be provided within HPSAs and additional physicians will benefit from this valuable program.

How can Congress help incentivize Medicare GME in Indian Health Service facilities?

American Indians and Alaska Natives are disproportionately affected by many chronic conditions, including heart disease, cancer, diabetes, and stroke, as well as unintentional injuries (accidents). American Indians and Alaska Natives are three times as likely as White individuals to be diagnosed with diabetes and to receive late or no prenatal care. They also have a lower life expectancy than their White counterparts. This is only compounded by high provider staff shortages serving these populations which is demonstrated by the fact that, in 2018, the "overall vacancy rate for…physicians…was 25 percent" within the Indian Health Service (IHS). Moreover, "financial barriers are a commonly cited reason for American Indian or Alaska Native students not pursuing or staying in medical school." As such, it is imperative to strengthen programs that not only support diversifying our health care work force but also

help to provide much needed medical care to our underserved American Indian and Alaska Native populations.

The loan repayment program within IHS provides $40,000 to physicians who serve for two years in health facilities that serve American Indian and Alaska Native communities. "Opportunities are based on Indian health program facilities with the greatest staffing needs in specific health profession disciplines. Loan repayment program participants can extend their contract annually until their qualified student debt is paid off." However, the payments received through the loan repayment program are taxable. In order to align this loan repayment program with other similar programs the loan repayments received should be tax free.

Congress can also provide an incentive by increasing compensation for IHS physicians to a level that is competitive with other federal agencies. Additional funding should be provided to this program to increase the number of providers who can be supported and, in conjunction with the improvement of service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available workforce and the level of professional expertise available for consultation within the IHS. Additionally, increased continuing education opportunities should be provided for physicians serving these communities, especially those in remote areas, and increased peer contact should be provided, both to maintain a high quality of care and to avert professional isolation.

What barriers exist for hospitals in rural and underserved areas to launch new residency programs supported by Medicare GME?

Rural hospitals play a very important role within communities. For example, in "2020, rural hospitals supported one in every 12 rural jobs in the U.S. as well as $220 billion in economic activity in rural communities." However, between 2010 and 2021, 136 rural hospitals closed. These closures only compound the problems experienced by the current HPSAs. In addition, these closures have contributed to unequal access and distribution of providers since about 20 percent of the U.S. population lives in rural communities, but only 10 percent of physicians practice in such areas. Furthermore, with our aging physician workforce, it is projected that there will be about a quarter fewer rural physicians practicing by 2030.

An AMA issue brief provides additional background and information on the challenges, costs, and strategies related to the delivery of care in rural hospitals. It also includes strategies to improve rural health and hospital viability.

What other telehealth flexibilities should the working group consider that would benefit resident physicians who are being trained in teaching hospitals, particularly those located in rural or underserved areas?

Although there are a number of positive uses for telemedicine in rural areas, implementation of such technologies could be significantly more robust. This is in part due to limiting factors such as high startup

costs and limited internet access in rural areas. Furthermore, physician practices and other facilities may lack the requisite hardware, software, and internet connection to provide reliable and high quality remote care. Internet access has been called a "super determinant" of health and yet approximately 19 million people in the United States do not have reliable broadband service. Accordingly, it is imperative that there are reliable broadband connections on site for both the provider and the patient to ensure that consistent, reliable care can be provided virtually. Therefore, to guarantee that remote care can be offered, it is vital to first ensure that the infrastructure for remote care services is in place.

Despite the challenges noted above, an informative report by the Assistant Secretary for Planning and Evaluation (ASPE) reveals sustained above-prepandemic levels of telehealth utilization among Medicare beneficiaries, notably for behavioral health and primary care visits. This sustained utilization highlights the importance of telehealth in bridging access gaps, particularly for vulnerable populations due to the severity and complexity of their illnesses. The findings from ASPE highlight the critical role of telehealth in maintaining continuity of care and suggest a pressing need for policies that support the permanent integration of telehealth services within the Medicare program.

Thus, the Administration should build out, and make permanent, initiatives like the Connected Care Pilot Program which provides funding for "eligible costs of broadband connectivity, network equipment, and information services...." Moreover, it is exceptionally important that these initiatives focus on rural areas that tend to have the worst broadband access. Consequently, programs like the Rural Health Care Program and the Rural Telehealth Initiative Task Force should be provided with additional support, potentially through the Internet for All Initiative, so that broadband access can be provided to these communities as quickly as possible.

CONNECT For Health Act and the Telehealth Modernization Act

An Agency for Health Care Research and Quality (AHRQ) funded study analyzing over four million primary care encounters highlights telehealth's role in maintaining health care utilization levels without contributing to overutilization. This study's results challenge concerns about potential increased health care utilization due to telehealth expansion, reinforcing telehealth's value as a viable alternative to in-person encounters when deemed appropriate. Given these insights, it is important for legislation like the CONNECT for Health Act and the Telehealth Modernization Act to pass, ensuring telehealth's role as a cornerstone of accessible, efficient health care delivery.

Remote Supervision of Residents

The Accreditation Council for Graduate Medical Education (ACGME) allows for audio/visual supervision of residents and its guidelines state that direct supervision can occur when "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology." Therefore, in accordance with ACGME guidance, the AMA acknowledges and supports individually tailoring the virtual supervision of each resident according to their level of competency, training, and specialty since

this would enable residents to provide additional services while still garnering the support needed from their teaching physicians.

However, guardrails should be included to ensure virtual supervision is delivered efficaciously and to mitigate risk. As such, the AMA recommends:

- Decisions regarding how residents will be supervised via audio/visual real-time communication technology should be implemented, reviewed, and overseen at the program level, in accordance with ACGME policy.
- Training programs should lay out audio/visual supervision requirements in advance to promote consistent understanding between the resident and the teaching physician. Each program must define when the physical presence of a supervising physician is required, and each resident must know the limits of their scope of authority.
- Advice from ACGME should be provided on when and how physicians must inform the patient that direct supervision by interactive telecommunication technology is being used.

Since a teaching physician will still be required to review the resident physician's interpretations and services, and ACGME has strict limits concerning supervision via interactive telecommunications technology, the AMA believes that the appropriate level of patient care and teaching physician direction will be maintained. Moreover, the permanent addition of audio/visual supervision would not change the responsibility of the institutions' GME Committees which would still be required to monitor programs' supervision of residents and ensure that supervision is consistent with the provision of safe and effective patient care, the educational needs of residents, the progressive responsibility appropriate to residents' level of education, competence, and experience, and any other applicable common and specialty/subspecialty specific program requirements.

The AMA believes that—if ACGME rules are adhered to, and the use of audio/visual real time communication equipment is individualized to support the needs of residents, teaching physicians, and their patients—this tool will be effective and will provide appropriate supervision, frequent evaluation, and open discussion. Therefore, in alignment with AAMC and ACGME, the AMA believes that there should be a permanent expansion of supervision of residents via audio/video real-time communications technology in all areas, especially since these methods of supervision were successfully employed for multiple years throughout the COVID-19 pandemic.

How can existing rural track programs be strengthened and expanded through Medicare GME?

The Rural Residency Planning and Development (RRPD) program improves and expands "access to health care in rural areas by developing new, sustainable rural residency programs or rural track programs (RTPs) that are accredited by the ACMGE, to address the physician workforce shortages and challenges faced by rural communities. This program provides start-up funding to RRPD award recipients to create

new rural residency programs that will ultimately be sustainable long-term through viable and stable funding mechanisms such as Medicare, Medicaid, and other public or private funding sources."

The Consolidated Appropriations Act, 2021 made some positive changes to RTPs, including removing the separately accredited requirement, allowing urban hospitals to create multiple RTPs and receive an RTP cap adjustment for each new RTP started, and excluding residents training in an RTP from the three-year rolling average while in the five-year cap building phase. However, additional leniencies and funding would help to increase the creation of these important tracks.

Since there are so many positive benefits to RRPD programs, additional support should be provided so that more institutions are incentivized to create them. One way to provide this additional support is to pass the Rural Residency Planning and Development Act of 2024 (H.R. 7855), which would codify the RRPD program. This legislation is a great example of some of the permanent and meaningful fixes that Congress can make to help provide additional training pathways for physicians who want to provide much needed care in rural communities.

Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?

The AMA does not believe that the creation of a GME Policy Council would be beneficial. Though we appreciate the recognition that there should be a better mechanism to distribute slots to specialties in shortage that does not require Congressional action, we believe that there are already bodies in place that could undertake this responsibility. Moreover, we would like to note that we do not believe that slots should be limited to only specific specialties since shortages exist across the entire physician workforce.

How much time do hospitals with low GME caps need to reset their caps?

If a cap is still in place, we support "Cap-Flexibility," which would allow these hospitals with low GME caps to extend their cap-building window for up to an additional five years beyond the current five-year window (for a total of up to 10 years). However, we would also support an even longer timeframe to reset these caps.

Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?

We support the ability for additional hospitals to be eligible to reset their low GME caps but defer to AAMC and ACGME to suggest appropriate eligibility criteria.

Legislation

To help alleviate the current and impeding physician shortage we strongly support and urge passage of:

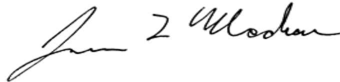
- H.R. 2389/ S. 1302 the "Resident Physician Shortage Reduction Act," which would increase Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots.
- H.R. 4942/ S. 665 the "Conrad State 30 and Physician Access Reauthorization Act," which would reauthorize the Conrad 30 waiver policy for an additional three years, as well as expand the total number of waivers available per state and make other targeted improvements to the program.
- H.R. 6205/S. 3211 the "Healthcare Workforce Resilience Act," would initiate a one-time recapture of up to 40,000 unused employment-based visas–25,000 for foreign-born nurses and 15,000 for foreign-born physicians–so they can strengthen and provide stability to the U.S. health care system. This temporary recapture period concludes three years after the date of enactment.
- H.R. 6980/ S. 2719 the "Directing Our Country's Transfer Of Residency Slots," or the " DOCTORS Act," would allow unused slots from the Conrad State 30 and Physician Access Reauthorization Act to be redistributed in the following fiscal year while ensuring that every state is still provided with 30 slots each year.
- S. 3189 the "Pathways to Practice Act of 2021," which would provide additional funding for the recruitment, education, and training of medical students willing to work in underserved communities.
- H.R. 1202/S. 704 the "Resident Education Deferred Interest (REDI) Act," bipartisan legislation that permits borrowers in medical or dental internships or residency programs to defer their student loans until completion of their educational training.
- H.R. 2761/ S. 705 the "Specialty Physicians Advancing Rural Care Act," or the "SPARC Act," would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage of specialty medicine physicians.
- S. 1403/ H.R. 3046 the "Medical Student Education (MSE) Authorization Act," would reauthorize the MSE Program which provides grants to expand or support graduate education for physicians.
- S. 3022 the "IHS Workforce Parity Act," which would amend the Indian Health Care Improvement Act to allow Indian Health Service Scholarship and loan recipients to fulfill their service obligations with the IHS through part-time clinical practice, helping to address the shortage of physicians in the IHS.
- H.R. 7050 the "Substance Use Disorder Workforce Act," would provide 1,000 additional Medicare-supported GME positions in hospitals that have, or are in the process of establishing, accredited residency programs in addiction medicine, addiction psychiatry, or pain medicine.
- H.R. 7258/ S. 3968 the "Community Training, Education, and Access for Medical Students (Community TEAMS) Act," would amend the Public Health Service Act to provide grants for training opportunities for medical students in rural health clinics, federally qualified health centers, and health care facilities located in medically underserved communities.
- H.R. 7855 the "Rural Residency Planning and Development Act of 2024," would amend the Public Health Service Act to authorize rural residency planning and development grant programs.

- Legislation to promote pathways to practice for the medical profession by providing additional funding for the recruitment, education, and training of medical students willing to work in rural and underserved communities. This would simultaneously achieve the important goal of diversifying the physician workforce in terms of economic background and geographic representation.
- Physician Shortage GME Cap Flex legislation, which would help to address our national physician workforce shortage by providing teaching hospitals an additional five years to set their Medicare GME cap if they establish residency training programs in primary care or specialties that are facing shortages.

Conclusion

The physician workforce shortage is well documented, and the aftermath of the COVID-19 pandemic has only served to magnify these workforce issues and other structural problems. The AMA thanks the Committee for its draft policy proposal and specific questions on policies under consideration related to the Medicare GME program. We look forward to working with the Committee and Congress to seek bipartisan policy solutions that will ensure that patients are provided the best care possible and that barriers are addressed to resolve the physician workforce shortage and preserve patient access to care.

Sincerely,



James L. Madara, MD