AMA
AMERICAN MEDICAL ASSOCIATION

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March 8, 2022

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

RE: RIN 2900-AR01—VA Pilot Program on Graduate Medical Education and Residency

Dear Secretary McDonough:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments on the Department of Veterans Affairs (VA) Proposed Rule "RIN 2900-AR01—VA Pilot Program on Graduate Medical Education and Residency." Due to the ever-increasing physician workforce shortage and the need for additional residency programs and slots, **the AMA is supportive of the VA pilot program and applauds the VA for implementation of this program.** As the largest professional association for physicians and the umbrella organization for state medical associations 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 the leader of the health care team. Programs like the VA pilot program 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.

The VA is seeking comments on the establishment of a new pilot program on graduate medical education (GME) and residency, as required by the Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018 (the MISSION Act). Specifically, the pilot program would create additional medical residency positions, enable the VA to fund residents training in covered facilities, and pay for certain costs of new residency programs. This program, known as the VA Pilot Program on Graduate Medical Education and Residency (PPGMER), is separate from the VA's general GME programming under 38 U.S.C. 7302(e) and is a time-limited pilot program that will sunset on August 7, 2031, unless statutorily reauthorized or made permanent.

The additional GME slots and funding will be enacted in covered facilities. A covered facility includes a health care facility operated by an Indian tribe or tribal organization, a health care facility operated by the Indian Health Service, a federally qualified health center, a health care facility operated by the Department of Defense (DOD), and other health care facilities deemed appropriate by the VA. Although a VA health care facility is a covered facility under the proposed rule, the VA does not anticipate the PPGMER being a vehicle for the placement of residents in VA facilities, since the VA intends to continue operating its GME programming to place residents in VA facilities separate from the PPGMER.[1]

[1] https://www.federalregister.gov/documents/2022/02/04/2022-02292/va-pilot-program-on-graduate-medical-education-and-residency.

The AMA supports the VA's implementation of PPGMER and recognizes the dire need for additional residency positions. Workforce experts predict that the U.S. will face a significant physician shortage for both primary care and specialty physicians over the next 13 years. In particular, the Association of American Medical Colleges (AAMC) predicts a shortage of 124,000 physicians by 2034, including a projected shortage of primary care physicians of between 17,800 and 48,000.[2] This in part is due to the aging U.S. population, which is growing in size and has more complex health needs, meaning that the demand for health professionals across the country will continue to grow. This shortage is also being caused by our aging physician population, many of whom will soon retire, leaving gaps in community care since there has not been a significant enough increase in medical students to fill their spots upon retirement.[3] Furthermore, the pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and underserved communities across the U.S. As such, more residency programs and slots are desperately needed to begin to address the current and impending physician shortage.

Additionally, as U.S. medical schools have increased enrollment, residency training positions at teaching hospitals have not kept up with the larger pool of applicants, limited by the cap on Medicare support for GME. While new medical schools are opening, and existing medical schools are increasing their enrollment to meet the need for more physicians, federal support for residency positions remains subject to a cap that does not represent the current needs of our nation. According to the AAMC, there has been a 52 percent increase in medical student enrollment since 2002,[4] but only a 17 percent increase in funded GME slots.[5] As such, **new residency programs like this pilot program by the VA are imperative to ensuring that our country's health care infrastructure will continue to grow to meet the needs of our aging population.**

Additionally, the populations that receive care from the covered facilities are particularly in need of additional providers. Indian tribes or tribal organizations, the Indian Health Service, federally qualified health centers, and health care facilities operated by the DOD are all experiencing severe physician shortages.

The Indian Health Service (IHS) provides health care to the approximately 2.2 million American Indian and Alaska Native (AI/AN) people who are members or descendants of 573 federally recognized tribes.[6] Unfortunately, the IHS has sizeable vacancy rates for clinical care providers. This has led to negative health outcomes for AI/AN people, including having a life expectancy that is 5.5 years less than all races in the United States and dying at higher rates than other Americans from preventable causes, including diabetes, suicide, chronic liver disease and cirrhosis, and chronic lower respiratory diseases.[7] "The ability to recruit and retain a stable clinical workforce capable of providing quality and timely care is critical for IHS."[8]

In 2016, the IHS reported that "an insufficient workforce was the biggest impediment to ensuring patients' access to timely primary care."[9] In conjunction with this report, HHS's Office of Inspector

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[2] https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage.
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7006215/.
[4] https://www.aamc.org/news-insights/us-medical-school-enrollment-rises-30.
[5] https://www.ncbi.nlm.nih.gov/books/NBK248024/.
[6] https://www.gao.gov/assets/gao-18-580.pdf.
[7] *Id*.
[8] *Id*.
[9] *Id*.

General stated that a lack of health care workers within the IHS limited services that could be rendered, decreased continuity of care, and lead to worse health outcomes.[10] "Federally operated IHS facilities, which received over 5.2 million outpatient visits and over 15,000 inpatient admissions in 2016" desperately need additional physicians.[11] "As of November 2017, the overall percentage of vacancies for physicians, nurses, nurse practitioners, CRNAs, certified nurse midwives, physician assistants, dentists, and pharmacists in these areas was 25 percent, ranging from 13 to 31 percent across the areas."[12] This has led to staff burnout, forced patients to have to travel great distances to be treated, and has caused many providers to leave positions with the IHS.[13]

Federally Qualified Health Centers (FQHC) are experiencing similar physician shortage problems. FQHCs "are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas."[14] As of 2020, FQHC's provided primary care to about 30 million people, including 9 million children.[15] Of these 30 million patients, 91 percent were low income, 81 percent were publicly insured or uninsured, and 63 percent were members of racial and ethnic minority groups.[16] However, FQHCs have found it hard to recruit physicians, which has caused physician positions to remain vacant.[17] For example, there are more than 7,200 federally-designated health professional shortage areas (HSPAs) where dire access issues persist for patients in both rural and urban underserved communities, and in both primary and specialty care.[18] The Health Resources and Service Administration (HRSA) estimates that an additional 32,494 physicians are required to eliminate all current primary care, dental, and mental health HPSAs.[19]

However, "partnerships with teaching programs offer FQHCs an avenue to reduce this shortage. One study found that 91 percent of residents who train under the Teaching Health Center Graduate Medical Education program (75 percent of the training sites are FQHCs) remain in primary care practice, and about 76 percent practice in underserved regions of the country."[20] As such, the implementation of PPGMER will have both the short term benefit of placing additional physicians in FQHCs and the long-term benefit of training providers that are highly likely to remain practicing in underserved regions.

Finally, health care facilities operated by the DOD are also experiencing shortages. "The Department of Defense (DOD) provides health care to more than 9.4 million beneficiaries worldwide and relies on more than 16,000 active and reserve component military physicians to serve the eligible beneficiary population."[21] From fiscal years 2011 through 2015, each service branch was consistently below 80 percent of authorizations in 19 physician specialties, 11 of which are designated as critically-short wartime specialties (see the chart below).[22] It is particularly difficult for the DOD to recruit physicians

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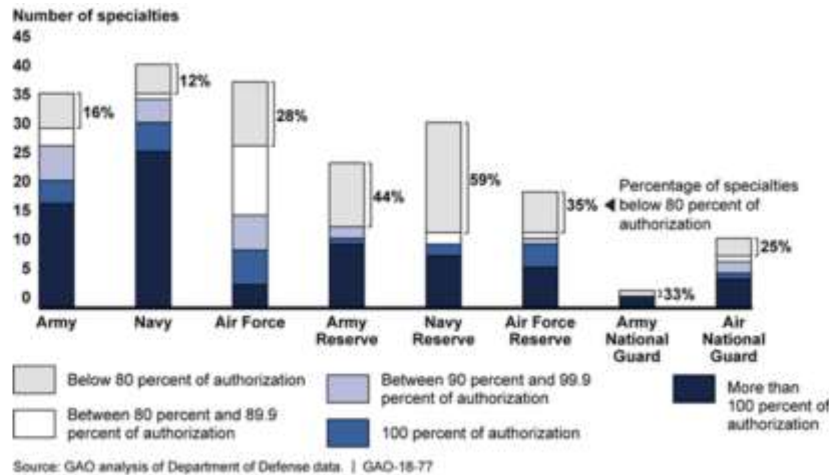
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] *Id*.
[14] https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html.
[15] https://jamanetwork.com/journals/jama/article-abstract/2777729?resultclick=1.
[16] https://jamanetwork.com/journals/jama/article-abstract/2777729?resultclick=1.
[17] https://www.fqhc.org/blog/2017/4/27/unusual-hospital-fqhc-partnerships-address-payment-and-access-issues.
[18] https://www.aamc.org/news-insights/attracting-next-generation-physicians-rural-medicine.
[19] https://data.hrsa.gov/topics/health-workforce/shortage-areas.
[20] https://www.fqhc.org/blog/2017/4/27/unusual-hospital-fqhc-partnerships-address-payment-and-access-issues.
[21] https://www.gao.gov/products/gao-18-77.
[22] https://www.gao.gov/products/gao-18-77.

due to the general physician shortage, lower salaries, and the lack of having its own medical student recruitment process.[23]

Number of Military Physician Specialties That Were Below Authorizations, Fiscal Year 2015



As such, an increase in residents, and funding for residency programs, is exceptionally important for the facilities covered by PPGMER. The placement of additional residents within these covered facilities will increase the likelihood of those physicians continuing to practice within the community and, if a significant number of residents are trained in the pilot program, this will undoubtedly contribute to decreasing the current physician shortage that our nation is experiencing.

Additionally, the monetary contributions that PPGMER will make in the form of resident stipend benefits, costs associated with new residency programs, curriculum development costs, recruitment and retention of faculty costs, accreditation costs, faculty salary costs, and resident education expense costs will strengthen existing programs and help to build new programs. This increase in funding will help these facilities provide better care to patients and attract and keep residents even beyond those participating in the pilot program. If possible, it would be beneficial to also offer residents in the pilot program scholarships while participating in PPGMER. This will help to attract more residents and will increase diversity among the residents within PPGMER.

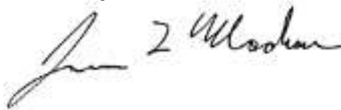
The AMA understands that the administration of the program will take place through a VA Central Office that will issue a request for proposal to VA health care facilities to announce opportunities for residents to be placed in covered facilities and to have costs paid or reimbursed. PPGMER is not considered a public funding opportunity and as such, the pilot is not allowing entities to apply or submit proposals to the VA to consider placing residents in their covered facilities. Instead, in administering the pilot program the VA will rely on the academic affiliations that it has formed with sponsoring institutions to delineate the responsibilities regarding the training of the residents, and the VA will enter into other separate agreements to control funding. As such, the institutions that the VA has academic affiliations with will be the only institutions that can participate in PPGMER and thus gain additional resident slots and funding. Therefore, the VA does not control the pool of participating educational programs or available residents, although the VA does assess the requirements to determine the best placement for such residents in covered facilities. Though we understand that the process that PPGMER is using to place residents is

[23] *Id*.

similar to the process utilized by the VA for their normal residency programs, **the AMA believes that additional benefits would be garnered by allowing proposals to be submitted to help determine resident placement within the covered facilities.** The application process may bring additional attention to the pilot program and allow for those programs that are most in need or best equipped to expand their programs and train additional residents.

Overall, the AMA is very supportive of this pilot program, the additional residency slots that will be created, and the additional funding that will be provided to enact the PPGMER. We encourage the VA to make this program as robust as possible by adding a significant number of residency slots, so that covered facilities will be able to provide the best possible care to those communities most in need. Thank you for considering the AMA's comments. If you have any questions, please feel free to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



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