

Dear All,

As you may know, today the AAMC has sent out an alert to their constituencies asking for support, especially cosponsors, for two bills currently in play regarding graduate medical education. They are informally known as the Nelson (S.973) and Crowley (HR 2251) bills.

This somewhat lengthy note is to inform you that the family of family medicine does not endorse these bills. In particular, we do not support the provisions contained in them that would increase the number of residency positions (slots) that Medicare would pay for by 15,000. The bills purport to be increasing mainly primary care residency positions, but that is not correct as well. There is no definition included as to what is primary care, and we know that most Internal Medicine and Pediatrics residents end up subspecializing.

Please contact your Senators and Representative and make sure they know that family medicine does not support the expansion of 15,000 residency slots, as contained in the Nelson/Crowley bills.

Here is the data:

- There are now (2007) nearly 28,000 residency positions. The number has grown dramatically since 2002, even with the Medicare cap on residency slots.
- The expected number of U.S. medical school graduates, in 2013, (with strong growth expected) will only equal 25,000 – leaving thousands of positions still available for U.S. born foreign medical school graduates and foreign born international medical graduates.
- As the Council on Graduate Medical Education (COGME) stated in its May 5 letter to Congress: “The nearly \$10 billion spent annually on GME (Medicare and Medicaid) is neither monitored nor regulated by the Federal government. Instead, the GME program portfolio is largely driven by the workforce needs of teaching hospitals. Current GME trends are not consistent with developing a more cost effective primary care-based health care system.”
- The relative growth of subspecialty positions is eroding the primary care base since it gives internal medicine and pediatric residents more options for leaving primary care. Internal medicine residents choosing to leave general internal medicine to sub-specialize grew from 2,965 to 3,913 between 1997 and 2006 – an increase of over 30%. Current data from the 2009 match suggest even greater erosion of primary care production in favor of subspecialization.

The academic family medicine organizations met last month and developed policy regarding legislative proposals that would expand residency positions, and other GME proposals. First, we do support one provision of the Nelson-Crowley bill; there is language that would fix the volunteer preceptor issue, including didactic training time. We are working to ensure that such language is included in both the Senate Finance and House Ways and Means Committees packages on health care reform, but we do not support the expansion of residency slots.

We have a recommendation for a new, modernization of GME funding for primary care training that we are working to gain support for on the Hill. We will be sending an alert out early next week on that front. I didn't want to confuse the issue by having two alerts at the same time, so chose to send this out on the list serves. (Be aware however that events are happening fast and furiously – alerts may be going out rapidly on many subjects. Please pay attention and respond, as this is our shot!)

Our efforts regarding graduate medical education training must be to reverse the current trend toward specialty and sub-specialty training that is wasting both Medicare dollars and causing reductions in quality of care for Medicare beneficiaries and the nation. The Nelson proposal to increase residency positions – and to have Medicare pay for the great expansion of positions that currently already exist outside of the current cap -- will not help bring down costs or increase primary care for the nation.

Here is our recommendation for how residency expansion should proceed – if at all.

Limit expansion of slots only to primary care slots (defined below)

- Definition of primary care - primary care slots (general internal medicine, general pediatrics, family medicine) should be counted five years after medical school graduation):
 - 1.) Look retroactively - Preference to qualify for new slots would be programs/hospitals that have a track record of producing true primary care physicians, as measured five years out from 1st year residency choice, **OR**
 - 2.) For programs/hospitals that don't have that record, they can be included if they commit to producing true primary care physicians. We would recommend providing an incentive up front - for a hospital/program that commits to producing primary care physicians -- in terms of allowing them new slots or additional funding. But --- based on a five year rolling average - we would count graduates that remain in primary care; if the programs/hospitals are not successful, they would have to pay back those incentives (GME/IME reimbursement) and would lose those slots.

Additional workforce principles that guide our view of bill language to support primary care training and workforce needs:

- Incentivize rural and underserved training.
- Incentivize students to choose primary care
- Efforts are needed to attract, develop and maintain faculty, especially if number of FM trainees begins to grow.
- Deferment of loans during residency
- Loan repayment amounts need to be high enough to attract students to choose primary care (consistent with debt incurred)