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Association of
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The Honorable Lisa Murkowski
709 Hart Senate Building
Washington D.C., 20510

Dear Senator Murkowski:

On behalf of the Society of Teachers of Family Medicine, the American Academy of Family Physicians, the Association of Family Medicine Residency Directors, the Association of Departments of Family Medicine, and the North American Primary Care Research Group, we would like to take this opportunity to thank you for your support of training programs that produce physicians who locate in, and serve, rural communities. We are grateful you are considering legislation to allow residency programs that are strong in rural training to remove the cap or limit on the number of residency slots that Medicare reimburses.

We believe that the language incorporated into the BBRA of 1999, that “the Secretary shall adjust the limitation under subparagraph (F) in an appropriate manner insofar as it applies to such programs in such rural areas **in order to encourage the training of physicians in rural areas** (emphasis added), gives the Secretary the authority to remove such caps.

In addition, the BBRA explicitly did not include a limit on residency slots for new rural training tracks, or integrated tracks. Family medicine has long supported the concept that you are pursuing of defining the integrated rural track in legislation or regulation in such a way as to allow a number of months of rural training serve as a basis for programs being excluded from the statutory limits on residency slots.

Parenthetically, we recognize that it is the institutions that are capped, not programs, but we believe an institution’s limit can be adjusted to allow for growth of a specific program.

The term “integrated rural track” is included in the statute, but has not been defined by CMS. Below is a portion of our comments that we submitted to CMS (then HCFA) in August 2000, in an attempt to achieve the same goals you are working toward today. We believe it makes the case for our joint position.

“We believe this term is in need of a definition since neither HCFA, nor Congress, has implemented it before. We propose that a program with a minimum of three months required rural training (integrated in any time frame in its curriculum) would be eligible to be considered “an accredited training

program with an integrated rural track”, and allow for the expansion of the cap on residency slots for that program.

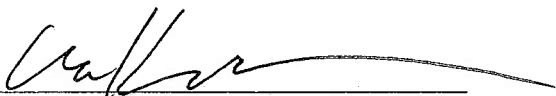
The literature supports the use of three months rural curriculum as a determinant for increased production of physicians who practice in rural areas. As we have submitted to you in previous communications, the production rate of rural physicians from separately accredited rural tracks is 68-100%. The rate for family practice programs in general is approximately 20 or 21%; for internal medicine and pediatrics programs the figure is about 7%.

If one looks at programs with three months rural curriculum time, the figure exceeds 50%. An article from the Journal of the American Board of Family Practice (Sept-Oct 1998) on The Case for the Development of Family Practice Rural Training Tracks clearly shows, in Table 1, that there is a direct relationship between time spent in rural training and production of graduates who serve in rural areas. Each month of additional rural time (until programs reached 4 to 6 months) increased production of rural physicians. After three months, the next big increase in production was at more than 22 months – the separately accredited rural training tracks discussed above. Clearly, the advantage of promoting programs that have shown a production of over 50% graduates serving in rural practices meets both the letter and the intent of this provision.

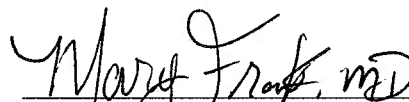
We also understand the need for HCFA to be able to implement these provisions in a manner that can be validated and confirmed. HCFA should be aware that the application for accreditation has three pages in which all the curriculum time is outlined for the 36 months of the program. Audits of these application forms can allow HCFA certainty that programs are in compliance. We have discussed family practice programs because that is where we have data, and it is what we know; however, there would be no reason why HCFA could not allow any training program, primary care, general surgery, or others to meet these criteria.”

In closing we are pleased to support your efforts to define, either in regulation or legislation, the term integrated rural training track (IRTT), and allow such programs to have the limit on their residency slots removed.

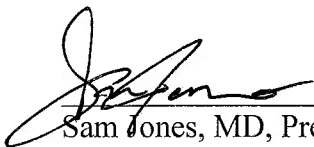
Sincerely,



Caryl Heaton, DO, President
Society of Teachers of Family Medicine



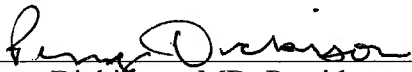
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