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Advancing Health in America

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The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Michael Bennet
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Marsha Blackburn
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable John Cornyn
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Catherine Cortez Masto
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bob Menendez
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Thorn Tillis
Committee on Finance
United States Senate
Washington, DC 20510

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

On behalf of AHA's nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to provide comment on sections of the Senate Finance Committee Bipartisan Medicare Graduate Medical Education (GME) Working Group's draft proposal.

We appreciate that the working group is considering ways to thoughtfully address the longstanding issue of physician shortages, particularly in rural and underserved areas. Following are our comments on your draft proposal. We look forward to working with

you to develop and enact legislation to address these critical shortages and ensure that the communities we serve have access to the health care services they need.

INTRODUCTION

Across the nation, our member hospitals and health systems and the patients we serve experience daily the strain of workforce shortages. According to the Association of American Medical Colleges, shortages are projected to exceed 86,000 physicians by 2036. Hospitals' ability to deliver quality, equitable care depends on attracting, retaining and supporting the dedicated health care workers essential to serving our patients and communities, and an adequate, well-trained workforce is necessary to meet that objective.

To ensure a sufficient supply of well-trained physicians, Congress enacted the Medicare GME program. However, based on projections of a physician surplus, Congress included provisions in the Balanced Budget Act of 1997 that froze the number of Medicare-funded physician training positions at 1996 levels and limited the number of residents that hospitals may include in their ratio of residents-to-beds, which determines indirect medical education (IME) payments. Now 27 years later, that 1997 law continues to severely restrict hospitals' ability to train the next generation of providers and has contributed to a shortage of physicians, especially in behavioral health, primary care and general surgery. Without congressional action, the limitation on the number of residents for which each teaching hospital is eligible to receive GME reimbursement remains a major barrier to easing physician shortages.

SECTION 2 — Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

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

The AHA has long supported the Resident Physician Shortage Reduction Act (S. 1302/H.R. 2389), bipartisan, bicameral legislation that would add 14,000 Medicare-funded residency slots over the next seven years. The bill would require the Government Accountability Office to study strategies for increasing health professional workforce diversity and report its findings and recommendations to Congress within two years of enactment.

Lifting the cap on Medicare-funded residency positions would enhance access to care and help hospitals better meet the needs of the communities they serve. Increasing Medicare-funded residency slots would provide hospitals more flexibility to diversify and maintain training programs, including both primary care and specialty programs. In

addition, an increase in slots would allow health systems to train residents in more diverse facility types, such as smaller rural hospitals that may not have sufficient resources to operate their own training programs. This would benefit the quality of physician education and the care rendered to their patients.

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

The Centers for Medicare & Medicaid Services (CMS') own data from the most recent round of allocations indicates that too few rural hospitals are applying for slots. Congressional efforts should be targeted toward policies that encourage rural hospitals to apply for residency slots rather than changing the definition of rural hospitals.

Beyond the proposed changes to the definition of rural hospitals, is it necessary to provide further clarification in the existing statute to ensure that CMS allocates GME slots to particular categories as specified in the CAA, 2023 GME allocation formula?

CMS continues to use the same method finalized in the FY 2022 inpatient prospective payment system (PPS) final rule to distribute additional residency slots. That is, at least 10% of the aggregate number of total residency positions would be made to each of the four categories of hospitals: 1) hospitals located in rural areas; 2) hospitals operating above their residency caps; 3) hospitals in states with new medical schools; and 4) hospitals that serve health professional shortage areas (HPSAs), prioritizing the fourth category based on the HPSA score. We have previously expressed to CMS concerns regarding the use of the HPSA scores to prioritize certain slots, which is detailed in our FY 2022 inpatient PPS proposed rule comment letter and a subsequent final rule comment letter.

We urged the agency in 2022 to prioritize slot distribution based solely on the four categories included in the law and give priority to hospitals that qualify in more than one, with the highest priority given to hospitals qualifying in all four categories. CMS' use of HPSA scores during the initial phase of the distribution "[did] not reflect statutory intent [and that] this reliance on HPSAs minimize[d] Congress' other priorities to expand training slots for hospitals in rural areas, training above their cap, and in states with new medical schools" and questioned whether it would meet statutory requirements.

We continue to urge our original approach and believe that it would be less burdensome and offer a clearer metric for qualifying hospitals. This approach is consistent with the statutory criteria, which do not place any additional emphasis on HPSA service areas or

scores, and it still supports teaching hospitals serving underrepresented and historically marginalized populations.

Section 4112 of the CAA,2023 requires the distribution of an additional 200 residency positions in FY 2026. At least 100 of those positions must be for psychiatry or psychiatry subspecialty residency training programs. The CAA limits a qualifying hospital to receiving no more than 10 additional full-time equivalents (FTEs), and CMS is proposing to first distribute slots such that each qualifying hospital receive up to 1.0 FTE. If any residency slots remain after distributing up to 1.0 FTE to each qualifying hospital, CMS will prioritize the distribution of the remaining slots based on the HPSA score associated with the program for which each hospital is applying.

For the slots that were distributed under Section 126 of the CAA of 2021, CMS is proposing, for the remainder of the distribution, to prioritize hospitals qualifying under category four, regardless of HPSA score, because the agency did not meet the statutory requirement to distribute at least 10% of the residents to each of the four categories.

How should Congress approach the role of hospitals which engage in "rural reclassification," wherein a hospital changes its designation from urban to rural, then back to urban within one calendar year for the purposes of receiving Medicare GME payment?

We are unaware of any circumstance in which a hospital has changed its designation for the express purpose of receiving Medicare GME slots.

How could Congress improve the recruitment of physicians to work in rural or underserved communities? For example, would adding criteria to allocate GME slots for hospitals affiliated with centers of excellence, HBCUs, or MSIs and for hospitals affiliated with non-academic hospital settings improve the distribution of physician training and recruitment in rural and underserved areas?

The AHA supports the following legislative proposals to increase the number of physicians working in rural and underserved communities.

Rural and Underserved Pathway to Practice Training Programs. The AHA supports the proposal to establish Rural and Underserved Pathway to Practice Training Programs, which would establish 1,000 medical school scholarships annually to promote medical workforce diversity and exempt residency positions filled by program graduates from statutory caps on residency slots. The program would incentivize those from rural and underserved communities to become physicians and to practice in those communities through a scholarship and stipend for qualifying medical students to attend medical school or post-baccalaureate and medical school. Students eligible for this

program include first-generation college or professional students; Pell Grant recipients; those who lived in a medically underserved, rural or health professional shortage areas; and graduates of historically Black colleges and universities.

The proposal would exclude from a hospital's residency caps those residents who participated in Rural and Underserved Pathway to Practice Training Programs at certain applicable hospitals that are recognized by the Accreditation Council for Graduate Medical Education for committing to train physicians with additional requirements, such as increased mentorship, structural and cultural competency training, and training in the community.

Conrad State 30 Program. We urge Congress to pass the **Conrad State 30 and Physician Access Reauthorization Act (S. 665 / H.R. 4942)** to extend and expand the Conrad State 30 J-1 visa waiver program, which waives the requirement to return home for a period if physicians holding J-1 visas agree to stay in the U.S. for three years to practice in federally-designated underserved areas.

International Workforce. The AHA urges Congress to pass the **Healthcare Workforce Resilience Act (S. 3211 / H.R. 6205)**, bipartisan legislation that would recapture 25,000 unused employment-based visas for foreign-born nurses and 15,000 for foreign-born physicians to help address staffing shortages.

Loan Repayment Programs. We urge Congress to pass the **Restoring America's Health Care Workforce and Readiness Act (S. 862)** to significantly expand National Health Service Corps funding to provide incentives for clinicians to practice in underserved areas, including rural communities. AHA also supports the **Rural America Health Corps Act (S. 940 / H.R. 1711)** to directly target rural workforce shortages by establishing a Rural America Health Corps to provide loan repayment programs focused on underserved rural communities.

SECTION 3 — Encouraging Hospitals to Train Physicians in Rural Areas

To address nationwide physician shortages in a timely manner, the AHA supports the distribution of additional Medicare-funded residency positions as required by the CAA of 2021. The CAA requires CMS to distribute at least 10% of the 1,000 slots to rural hospitals, a category that includes geographically urban hospitals that have reclassified as rural.

AHA supports this goal and we appreciate the working group's interest in ensuring that rural hospitals fully participate in the GME program. We share your dismay that few rural hospitals are applying for slots. According to CMS, in the first round of GME slot

allocations, only eight geographically rural hospitals applied, and five were granted slots.

The AHA is committed to working with Congress to assist rural hospitals with any financial, regulatory or administrative burdens that prevent them from applying for or receiving GME slots.

Additionally, the AHA supports the THCGME Program, which augments the primary care workforce by supporting primary care and dental residency programs and promoting opportunities for residents to provide care to underserved communities.

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

Rural hospitals and health systems are the lifeblood of their communities and are committed to ensuring local access to health care. At the same time, these hospitals are experiencing unprecedented challenges that jeopardize access and services. These include the aftereffects of a worldwide pandemic, crippling workforce shortages, soaring costs of providing care, broken supply chains, severe underpayment by Medicare and Medicaid, and an overwhelming regulatory burden.

Rural hospitals make up about 35% of all hospitals in the U.S. Nearly half of rural hospitals have 25 or fewer beds, with just 16% having more than 100 beds. Given that rural hospitals tend to be much smaller, patients with higher acuity often travel or are referred to larger hospitals nearby. As a result, in rural hospitals, the acute care occupancy rate (37%) is less than two-thirds of their urban counterparts (62%). Compared to their non-rural counterparts, a significantly higher percentage of rural hospitals are owned by state and local governments — 35% compared to just 13% of urban hospitals.

Recruitment and retention of health professionals have long been persistent challenges for rural providers. Acute workforce shortages and increasing labor expenses resulting from the pandemic have placed additional pressure on rural hospitals. Many rural providers are seeking novel approaches to recruit and retain staff. Existing federal programs, such as the National Health Service Corps, which the AHA strongly supports, work to incentivize clinicians to work in rural areas. Other programs, such as the Rural Public Health Workforce Training Network Program, help rural hospitals and community organizations expand public health capacity through health care job development, training and placement. Additional and continued support to help recruit and retain health care professionals in rural areas is needed from the federal government.

At the same time, hospitals exploring the establishment of residency programs confront daunting challenges. A new residency program can take approximately two years to establish, and start-up costs can be prohibitive — requiring resources that small rural hospitals cannot afford given their financial constraints.

What revisions to IME payment are needed in order to improve financial support for rural hospitals interested in establishing residency training programs, or otherwise improve the Medicare GME program to support rural hospitals?

Congress should ensure that Medicare Advantage (MA) plans are providing appropriate direct GME (DGME) payments to hospitals.

Medicare beneficiaries are increasingly enrolling in MA plans, which has implications for teaching hospitals and their GME payments. Medicare makes DGME payments for beneficiaries' inpatient hospital utilization. Generally, these payments are based on a hospital's per resident amount (PRA), a weighted number of FTE residents and the hospital's Medicare share of total inpatient days. Although the hospital's weighted FTE residents is subject to a cap, its PRA is updated for inflation, so DGME payments per resident increase over time.

While these payments will reflect growth in MA utilization, they are reduced to finance reasonable cost payments to hospitals receiving nursing and allied health (NAH) education payments based on their MA utilization.

Medicare also makes payments for traditional Medicare beneficiaries' share of hospital costs incurred in connection with approved education activities, including NAH programs. Unlike Traditional Medicare, MA NAH payments are subject to a dollar amount cap of $60 million annually, an amount that has not been updated since 1999. This cap is routinely reached each year. Thus, as beneficiaries move from Traditional Medicare to MA, hospitals' Traditional Medicare NAH payments are decreasing, but their MA NAH payments are not increasing (proportionately or otherwise).

These two limitations are eroding Medicare's support of GME. This is very troublesome given that hospitals and health systems already face mounting and critical physician shortages that will jeopardize access to care in communities across the nation. These and other clinician shortages — combined with an aging population, a rise in chronic diseases and behavioral health conditions, physician burnout and state-of-the-art care delivery advancements — all underscore the need for Medicare to at the very least maintain its GME funding. Without this support, it will be extremely difficult to adequately prepare America's health care workforce for the health system of the future and ensure continued access to care.

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?

CMS established that after the COVID-19 public health emergency (PHE), teaching physicians could meet requirements for key or critical portions of services through virtual presence (real-time, audio-visual communications technology) but only for services furnished in residency training sites in non-Metropolitan Service Areas (MSAs). During the COVID-19 PHE, flexibilities for virtual supervision were extended to include MSAs. CMS is exercising enforcement discretion through calendar year 2023.

The AHA has urged CMS to make permanent virtual supervision flexibilities for both MSAs and non-MSAs. Flexibilities to enable virtual supervision of residents in both non-MSAs and MSAs have improved access for patients and maximized limited teaching physician capacity. They have also provided real-world telehealth experience for residents across geographies, with physicians able to virtually supervise care safely and effectively. This will be essential in training the next generation of clinicians. In addition, provider shortages and staffing challenges are not limited to non-MSAs, particularly for specialties such as behavioral health.

SECTION 4 — Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

Does the existing Council on Graduate Medical education (COGME), a federal advisory committee that assesses physician workforce trends, fulfill the goals of this new Medicare GME Policy Council? How can Congress enhance the work of the COGME?

The AHA supports Congress providing robust funding necessary for COGME to carry out its responsibilities.

SECTION 5 — Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs

The AHA supports allowing hospitals with low caps to reset their caps. We do not have a recommendation for a specific time frame.

SECTION 6 — Improvements to the Distribution of Resident Slots under the Medicare Program after a Hospital Closes

Would the proposed changes to the formula for redistributing slots from closed hospitals improve the distribution of GME slots to regions of the country facing greater physician shortages?

To improve the distribution of resident slots after a hospital closes, we support the working group's proposal to retain the requirements that CMS distribute slots to hospitals in the same core-based statistical area and state as the closed hospital and to eliminate the requirement that CMS prioritize hospitals in the same region as the closed hospital.

CONCLUSION

We appreciate the working group's willingness to seek bipartisan solutions to the urgent crisis of physician shortages. We look forward to continuing to work with you to develop comprehensive legislation to help ensure that the Medicare GME program continues to meet the needs of patients and communities.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs