GME Advocacy Coalition

June 24, 2024

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

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

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

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

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

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

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

The Honorable Marsha Blackburn
357 Dirksen Senate Office Building
Washington, DC 20510

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

The nearly 50 undersigned members of the Graduate Medical Education Advocacy Coalition (GMEAC) appreciate the opportunity to respond to the Bipartisan Medicare Graduate Medical Education (GME) Working Group's Draft Proposal Outline and Questions for Consideration. Our groups appreciate your bipartisan efforts to further expand GME, which would have a tremendous impact on the physicians and teaching hospitals our groups represent and the patients and communities our members serve.

The U.S. is facing a shortage of between 13,500 and 86,000 physicians by 2036 – in both primary care and specialty medicine.[1] America's medical schools, teaching health systems and hospitals, and their physician partners are doing their part by investing in physician and health care provider training and leading innovations in new care delivery models that are more efficient and include better use of technologies that improve patient access to care. Even with these efforts, however, physicians continue to report record levels of burnout, physician

[1] The Complexities of Physician Supply and Demand: Projects from 2021 to 2036: https://www.aamc.org/media/75236/download?attachment

payments continue to fall well short of costs, and patients continue to struggle to access care. While numerous policy solutions are needed to sustain and bolster the physician workforce, increased Medicare support for GME is a key component to stabilizing the workforce expansion. With demand for physicians continuing to outpace supply as both the patient population and physician workforce age – it is critical now more than ever that Congress build on recent bipartisan efforts and invest in training more physicians.

The coalition is pleased to see that the working group is seeking ways to expand and improve Medicare-supported GME. Our organizations recognize the importance of this complex and consequential program, and submit the following responses to the working group:

Increase the Number of Medicare-Supported GME Positions

The undersigned members of the coalition strongly support a robust increase in the number of Medicare-supported GME positions. As you know, Medicare offsets a portion of a teaching hospital's training expenses through Direct Graduate Medical Education (DGME) payments. These expenses include resident stipends and benefits, faculty salaries and benefits, and allocated institutional overhead costs. This support, which is directly tied to the number of Medicare beneficiaries a teaching institution cares for, was capped by Congress as part of the Balanced Budget Act of 1997. Consequently, Medicare support for GME has been effectively frozen for a quarter century and as the population of the United States has grown, become more diverse, and geographically shifted, the Medicare GME has been unable to reflect these changes.

To address this issue, our coalition has long advocated for an increase in the number of Medicare-supported GME positions, and we express our gratitude to Congress for investing in additional positions in both the Consolidated Appropriations Acts (CAA) of 2021 and 2023. These two increases in Medicare-supported GME represent the first investments of their kind since 1997. The positions from the CAA, 2021 are already being distributed, and have driven high demand from teaching health systems and hospitals across the country. It is evident that more slots are needed by programs across the country, and new GME slots constitute vital investments for GME programs nationwide.

The GMEAC strongly supports the bipartisan Resident Physician Shortage Reduction Act (S. 1302/H.R. 2389), which would provide 14,000 new Medicare-supported GME positions over seven years. While more positions are necessary to completely close the gap, we believe this legislation represents a strong starting point for further increases in GME. As you contemplate the number of slots to include in this proposal, we urge you to consider the persistent patient access issues that already exist, and acknowledge that they will continue to worsen without additional investment in GME. The Resident Physician Shortage Reduction Act has broad bipartisan and bicameral support, as well as the support of over 80 members of our coalition.

While we have historically recommended an increase of 14,000 new Medicare-supported GME positions, we recognize the potential constraints facing the working group. That said, we urge you to include at least 10,000 residency slots. These new positions, along with the 1,200 from the CAA, 2021 and 2023, would represent significant progress towards ensuring access to care for patients and communities.

Changes to the CAA, 2023 Formula for Future Distributions

As previously mentioned, the coalition has long supported the Resident Physician Shortage Reduction Act, which served as the basis for the CAA, 2021 and 2023. The CAA, 2023 created 200 new Medicare-supported GME positions targeted at mental health physicians, with a requirement that no fewer than 10% be distributed to each of four categories of qualifying hospital:

- hospitals in rural areas, or treated as rural,
- hospitals that are over their Medicare FTE cap,
- hospitals in states with new medical schools or branch campuses, and
- hospitals that serve geographic Health Professional Shortage Areas (HPSAs).

Our groups believe that the distribution methodology set forth in the CAA, 2023, if implemented properly, would allow for a fair distribution of slots for a diverse representation of hospitals across the country. Our primary concern, however, remains in the way the Centers for Medicare and Medicaid Services (CMS) has chosen to interpret the methodology by over-prioritizing Health Professional Shortage Areas (HPSAs).

Members of our coalition cautioned against this approach in a 2021 letter to CMS regarding its initial proposed distribution of the CAA, 2021 positions in the FY 2022 Inpatient Prospective Payment System (IPPS) rule.[2] We noted that the statutory language specified that slots should go to the four categories of "qualified hospital." CMS, however, has continued to rely on a flawed distribution methodology, resulting in hospitals that would qualify under the four categories but may have a low, or no HPSA score being denied slots. While CMS initially stated that they would refine the process with stakeholder feedback, they doubled down on this over-prioritization in their FY 2025 IPPS rule, where they outlined the distribution process for the CAA, 2023 slots.

As a result, the GMEAC strongly urges the working group to include stringent statutory language directing CMS to adhere to the distribution methodology set forth in the legislation.

Targeting slots to specific specialties or regions

The working group has proposed earmarking some slots for specific specialties or primary care specialties, and it has also proposed increasing caps for hospitals in states with low numbers of GME slots instead of all hospitals. Our coalition is a diverse group representing primary care and specialty groups alike. Our members span the entire country and are in every state and community. We remain strongly concerned about shortages across both primary care and specialties. In fact, according to the Medicare Payment Advisory Commission (MedPAC), of those Medicare beneficiaries looking for a new primary care physician, half had difficulties finding one, and of those beneficiaries looking for a new specialist, one-third had difficulties finding one.[3]

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[2] https://www.aamc.org/media/55161/download

[3] MedPAC, Report to Congress, Medicare Payment Policy, Chapter 4 (Mar. 2023).

Additionally, while some states may appear to have more Medicare-supported GME slots, there are teaching hospitals in regions of most states that are in dire need of slots. We urge you to ensure that the distribution of slots is based on the specific needs of communities. Fewer slots at the state level may not necessarily mean a more dire workforce shortage, depending on population and demand.

Outreach and Technical Assistance to Rural Teaching Hospitals
The coalition urges the working group to discuss options to publicize the new Medicare-supported GME position applications through CMS. Additionally, some lead time prior to the application opening could be helpful for smaller and rural hospitals. As it stands now, the application goes live immediately, and hospitals must apply for the slots. We recommend a longer window to apply and a better strategy to communicate to hospitals that the application is open. We also urge you to continue engaging with rural teaching hospitals to determine what would be helpful.

We look forward to continuing to work with the working group and Senate Finance Committee as you advance GME policy.

Sincerely,
Association of American Medical Colleges
Alliance for Academic Internal Medicine (AAIM)
Alliance of Specialty Medicine
America's Essential Hospitals
American Academy of Allergy, Asthma & Immunology
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Board of Medical Specialties
American College of Academic Addiction Medicine
American College of Cardiology
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Gastroenterological Association
American Geriatrics Society

American Medical Association
American Society for Clinical Pathology
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Echocardiology
American Urological Association
California Hospital Association
College of American Pathologists
Congress of Neurological Surgeons
Greater New York Hospital Association
Healthcare Association of New York State (HANYS)
Healthcare Leadership Council
Heart Failure Society of America
Heart Rhythm Society
Medical Group Management Association
National Association of Spine Specialists
Premier Inc.
Society for Vascular Surgery
Society of Hospital Medicine
Society of Interventional Radiology
Society of Neurological Surgeons
The American Society of Breast Surgeons
The Hospital and Healthsystem Association of Pennsylvania
The Society of Thoracic Surgeons
Vizient, Inc.