American Hospital Association™
Advancing Health in America

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January 31, 2025

The Honorable Bill Cassidy, M.D.
United States Senate
455 Dirksen Senate Office Building
Washington, DC 20510

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

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

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

Dear Senators Cassidy, Cortez Masto, Cornyn and Bennet:

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 your draft Medicare graduate medical education (GME) reform package (KEL24743 MP2).

We appreciate your thoughtful consideration of addressing longstanding physician shortages, particularly in rural and other underserved areas, through your draft bill, which would fund 5,000 new physician residency slots nationwide and effect other changes to Medicare GME funding. We look forward to working with you to develop and enact legislation to alleviate critical physician shortages and ensure that the communities we serve have access to the health care services they need.

Across the nation, our member hospitals and health systems and the patients we serve experience daily the strain of workforce shortages, which are now projected to exceed 180,000 physicians by 2037, according to the Health Services and Resources Administration (HRSA). 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 those objectives.

To ensure a sufficient supply of well-trained physicians, Congress created the Medicare GME program. However, based on erroneous physician surplus projections, 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 28 years later, that 1997 law continues to severely restrict hospitals' ability to train the next generation of providers and 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.

To mitigate these shortages, the AHA, along with several other national organizations, has long supported the Resident Physician Shortage Reduction Act — bipartisan, bicameral legislation that would add 14,000 Medicare-funded residency slots over seven years. Additionally, the legislation would require the Government Accountability Office to study strategies for increasing the diversity of the health professional workforce 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 expand training programs, including both primary care and specialty programs. In addition, an increase in slots would allow health systems to train residents in more 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 care rendered to their patients.

Additionally, we appreciate your attention to addressing shortages in rural communities. Rural hospitals compose 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.

Recruitment and retention of health professionals have long been a persistent challenge for rural hospitals. 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.

Following are our responses to specific provisions in the draft legislation.

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

You asked whether the 30-slot cap proposed in Section 2 of the draft would be appropriate for the distribution of residency slots across hospitals. The AHA supports the 30-slot cap and fully understands the need to ensure that hospitals across all geographical areas and types have a fair opportunity to compete for slots. We recommend that, as the 5,000 slots are being awarded, should any slots be unused, those hospitals that have received 30 slots (and are therefore ineligible to receive additional ones) be afforded the opportunity to apply for them. Newly funded Medicare residency slots should be allocated efficiently and fully distributed to hospitals.

Changes to the Per Resident Amount (PRA)

We appreciate the attempt to update the current per-resident amount (PRA), which is insufficient for many teaching hospitals. The PRA was based on the direct costs of a teaching hospital in the 1980s and does not reflect the actual GME costs hospitals now incur. As such, we support approaches that better align the PRA to current cost structures, including increasing the PRA for hospitals that serve historically marginalized and underserved populations. However, this proposal does not appear to do so. In fact, the proposal appears to reduce the PRA for certain teaching hospitals, which would create financial instability for the targeted facilities that are applying for slots.

We strongly recommend that you consider the implications this provision may have on hospitals whose support may decrease as a result of these changes.

SECTION 3 — Encouraging Hospitals to Train in Rural Areas

We support expanding the Medicare Rural Hospital Flexibility Program to assist all rural hospitals in applying for and securing Medicare GME slots.

Remote supervision of residents in rural teaching settings has been a key enabler to expand training opportunities, maximize limited supervising physician capacity, and increase access to care in areas with physician shortages. Specifically, remote supervision flexibilities have allowed teaching physicians to meet requirements for key

or critical portions of services through virtual presence (real-time audio-visual communications technology). Historically, supervision required the immediate in-person availability of the supervising practitioner.

In 2021, the Centers for Medicare & Medicaid Services (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 and then through the calendar year 2024, waivers for virtual supervision were extended to include MSAs. we support permanently extending virtual supervision flexibilities across teaching settings.

In 2024, CMS limited virtual supervision flexibilities to apply in clinical instances when the service was furnished completely virtually, with no in-person component. However, for many hospitals and health systems, supervising physicians may be geographically dispersed or balancing supervisory functions with care delivery and administrative tasks. We encourage flexibility to maximize the benefit of virtual modalities (i.e., to connect geographically dispersed supply with demand). For example, there may be instances where the resident is physically with the patient and the supervising physician is at a different location. The resident should be able to "dial in" the supervising physician in these instances. We urge Congress to codify virtual supervision flexibilities permanently and extend flexibilities for virtual services and instances where the resident and patient may be in the same location and the supervising physician is remote.

In addition to remote supervision flexibilities, other complementary policies can support access to care, especially in areas with physician shortages. For example, we have supported the expansion of services eligible for the primary care exception. The primary care exception allows teaching physicians to bill for certain services performed by residents in certain training settings when the physician is not present with the resident so long as certain conditions are met. Expanding eligible services, such as including higher levels of evaluation and management services, would allow more time for physicians to perform supervisory (including being immediately available) and other duties while enabling residents to practice to the fullest extent of their skills and training. This may particularly benefit rural areas with limited primary care capacity.

Additionally, 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 create Rural and Underserved Pathway to Practice Training Programs, which would establish 1,000 medical school scholarships

annually to promote diversity in the medical workforce and exempt residency positions filled by graduates of this program 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, and those who live in medically underserved, rural or health professional shortage areas.

- Conrad State 30 Program. We urge Congress to pass the Conrad State 30 and Physician Access Reauthorization Act 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, 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 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 to directly target rural workforce shortages by establishing a Rural America Health Corps to provide loan repayment programs focused on underserved rural communities.

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

You also asked the AHA's view on creating a GME Policy Council to guide future slot allocations. We believe a council would be redundant, as the Council on Graduate Medical Education (COGME), under the HRSA, is charged with advising and making recommendations to the Department of Health and Human Services Secretary and Congress on numerous areas involving physician workforce adequacy and training. We would support expanding the focus and responsibilities of COGME rather than creating an additional entity to make recommendations on those matters.

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 permanently.

SECTION 7 — Improving GME Data Collection and Transparency

We appreciate that your draft legislation explicitly requires reporting on federal GME programs by CMS and that CMS would be required to utilize existing data collected through Medicare Cost Reports and other entities to compile such reports. It is our understanding that CMS already collects the data enumerated in the draft.

To the extent that additional reporting by hospitals would be necessitated by this provision, we have specific concerns. First, for small hospitals, the requirement to report would be overly burdensome, and, in some instances (e.g., specialty, gender and race/ethnicity) it raises privacy concerns given the small size of some residency programs. Further, we are uncertain what program concern is related to the need for data on the remediation, probation, transfer, withdrawals or dismissals of residents.

Conclusion

We appreciate your willingness to seek bipartisan solutions to address the urgent need for additional physician residency slots. We look forward to continuing working with you to develop comprehensive legislation to help ensure 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