



**Association of  
American Medical Colleges**  
655 K Street, NW, Suite 100, Washington, DC 20001-2399  
T 202 828 0400  
aamc.org

June 21, 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

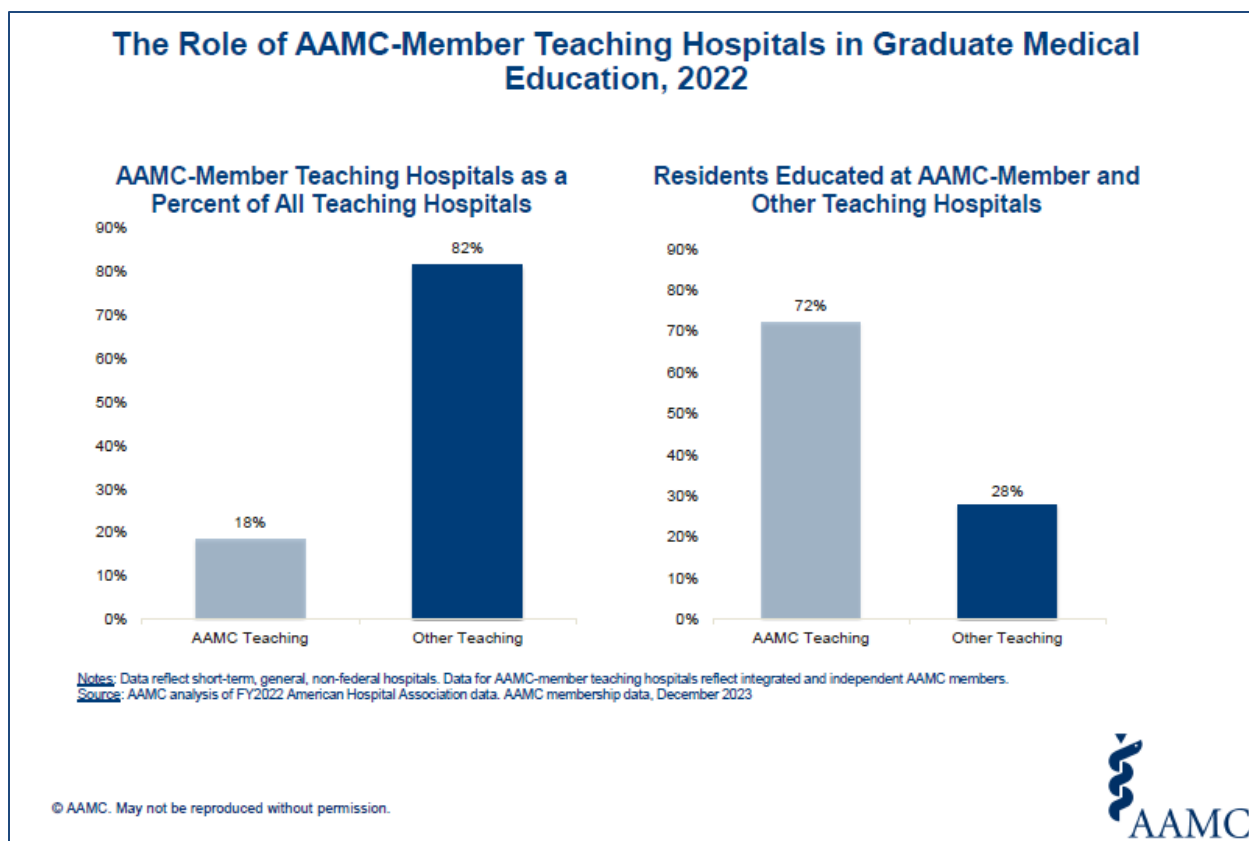
Dear Chairman Wyden and Sens. Menendez, Cornyn, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

The Association of American Medical Colleges (AAMC) welcomes the opportunity to respond to the Bipartisan Medicare Graduate Medical Education (GME) Working Group's Draft Proposal Outline and Questions for Consideration. The AAMC appreciates your bipartisan commitment to ensuring patient access to care through increased investment in Medicare-supported GME. We look forward to continuing to engage with you as you develop legislation in this space.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the [Liaison Committee on Medical Education](#); 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of

Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

Working in partnership with the nation’s medical schools, AAMC member teaching health systems and hospitals represent only 5% of all inpatient U.S. hospitals – and yet they train 72% of residents nationwide.<sup>1</sup> Our member teaching health systems and hospitals, despite being a small percentage of hospitals, operate 100% of comprehensive cancer centers, 72% of burn unit beds, 61% of level-one trauma centers, and 63% of pediatric intensive care unit (ICU) beds.<sup>2</sup> Our members also provide 32% of hospital charity care nationwide, and receive approximately 60% of the National Institutes of Health’s (NIH) extramural research funding. Our institutions, clearly, are dedicated to their missions of patient care, education, research, and community collaborations, and serve as pillars of the communities in which they are located.



Though our members are responsible for educating and training the next generation of physicians, the U.S. still faces a projected shortage of up to 86,000 doctors, including both

<sup>1</sup> AAMC analysis of FY2022 American Hospital Association data, AAMC membership data, December 2023.

<sup>2</sup> AAMC analysis of FY2022 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute’s Office of Cancer Centers, 2022. AAMC membership data, December 2023.

primary care and specialty physicians, by 2036.<sup>3</sup> Medical schools have already done their part to address this shortage by increasing enrollment by nearly 40% since 2002. Enrollment numbers are currently at their highest level and over 30 new MD-granting medical schools have opened since 2002. These strides only tell part of a success story. We must also increase the number of Medicare-supported GME residency positions for these students to become practicing physicians. To help support physician training, there exists a constellation of critical workforce programs administered by the federal government, one of which is Medicare-supported GME. Outside of teaching health systems and hospitals' own resources, Medicare is the largest explicit funder of residency training.

The AAMC is pleased that the working group is looking at ways to expand and improve Medicare-supported GME. This is an extraordinarily complex and consequential program, and the AAMC urges the working group to continue its deliberative approach to further exploring these policies. While the AAMC believes that GME is a crucial part of physician training, it is not a panacea for structural issues in the health care system. As you continue to refine this proposal, we urge you to carefully consider whether GME is indeed the appropriate policy lever for certain desired workforce outcomes.

The AAMC appreciates the bipartisan efforts required to put together this proposal, and submits the following responses to the working group:

## **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?**

Medicare supports the training of residents through Direct Graduate Medical Education (DGME) payments which help offset a portion of the training expenses such as 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.<sup>4</sup> To that end, Medicare support for GME had been effectively frozen for nearly a quarter century.

To help remedy the situation, the AAMC and its Congressional partners have long championed an increase in the number of Medicare-supported GME positions, and we are grateful that Congress invested in additional positions in both the Consolidated Appropriations Act (CAA), 2021 and 2023.<sup>5</sup> These two increases in Medicare-supported GME marked the first investments of their kind since 1997. As the U.S. population has grown, become more diverse, and geographically shifted, Medicare GME has been unable to mirror these changes. While the

---

<sup>3</sup> The Complexities of Physician Supply and Demand: Projections From 2021 to 2036:  
<https://www.aamc.org/media/75236/download?attachment>

<sup>4</sup> P.L. 105-33.

<sup>5</sup> P.L. 116-206, P.L. 117-238.

nation's teaching health systems and hospitals have been inappropriately criticized over the years for the perceived concentration of positions in certain regions, we must emphasize that these institutions have been leaders in helping ensure and support access to care in their communities by their commitment to investing in physician training despite nearly a quarter-century of restrictions on the program. In fact, the AAMC urges the working group to consider that many maldistribution issues in the program could be resolved by additional positions and increased investment in Health Resources and Services Administration (HRSA) workforce programs. The AAMC is strongly supportive of programs such as Children's Hospitals Graduate Medical Education (CHGME), Teaching Health Center Graduate Medical Education (THCGME), and the Title VII workforce programs – all of which play key roles in increasing the number of physicians and need increased investment.

The AAMC 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 7 years. While more positions would be needed to completely close the gap, we believe it is a strong starting point for additional increases in GME. We urge the working group to note the high demand for the new slots provided over the last two position distributions from the CAA, 2021. Hundreds of hospitals have applied for the slots, despite knowing that their chances of receiving awards are slim due to the small number available and the Centers for Medicare and Medicaid Services' (CMS') flawed distribution methodology. It is clear that more slots are needed by programs in every corner of the country, and new GME slots are important investments for residency programs everywhere.

As you consider the number of slots to include in this proposal, it is important to note that one slot does not "equal" one physician because residencies span multiple years. For example, to train one primary care doctor, typically a three-year residency, would technically require three slots, one for each year of the residency program. This is because programs generally need to "backfill" positions when a resident advances to the next post-graduate year (PGY). Residencies can last anywhere from 3 to 7 years. The AAMC projects a shortage of up to 86,000 physicians by 2036. Additionally, the AAMC's "Health Care Utilization Equity" scenario finds that if underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the U.S. would need an additional 117,100 to 202,800 physicians just to meet current demand.<sup>6</sup> These estimates, which are separate from the 2036 shortage projection ranges, illustrate the magnitude of current barriers to care and provide an additional reference point when gauging the inadequacy of physician workforce supply.

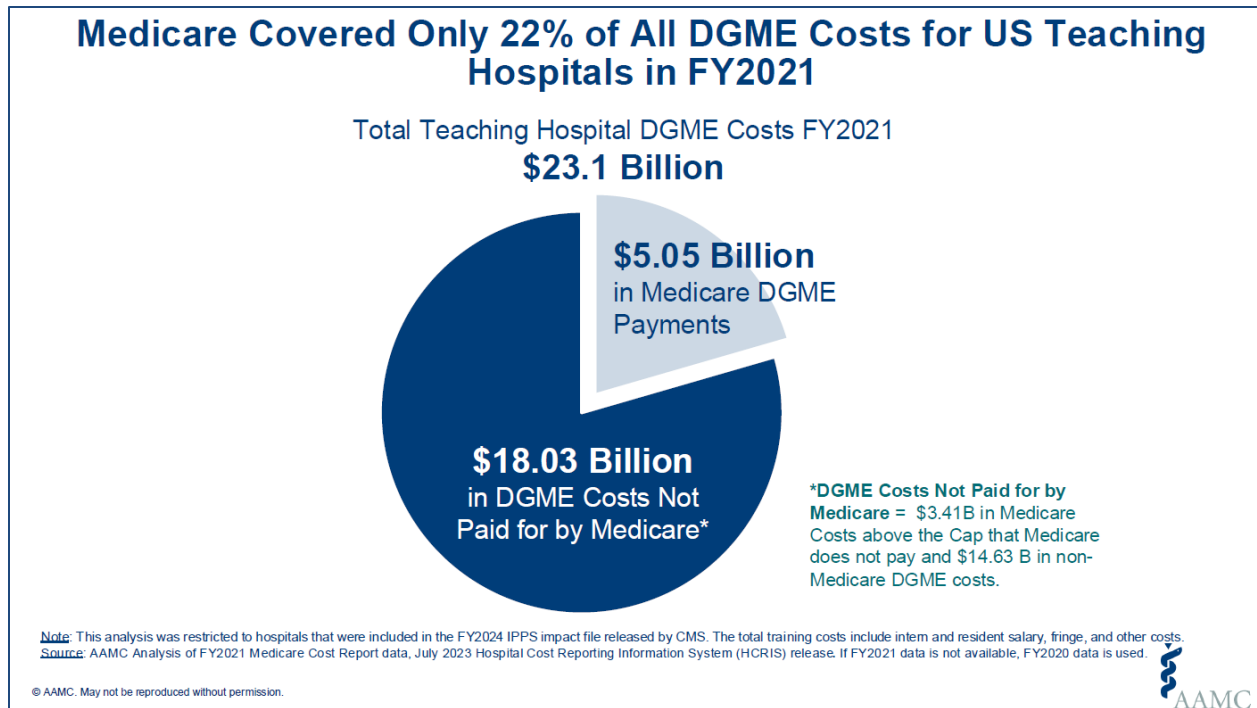
Should Congress add 14,000 new residency positions, as included in the Resident Physician Shortage Reduction Act, it would in reality provide only an additional 3,500 new physicians each year once fully implemented. While we have historically recommended an increase of 14,000 new Medicare-supported GME positions, we recognize the potential constraints facing the working group. That said, we urge you to include 10,000 residency slots. These new positions, along with the 1,200 from the CAA, 2021 and 2023, would represent significant progress

---

<sup>6</sup> The Complexities of Physician Supply and Demand: Projections From 2021 to 2036:  
<https://www.aamc.org/media/75236/download?attachment>

towards ensuring access to care for patients and communities.

AAMC-member teaching health systems and hospitals train approximately 77,000 residents across the country. Of these residents, Medicare supports approximately 57,000 trainees, meaning these teaching health systems and hospitals are fully funding the training of nearly 20,000 residents.<sup>7</sup> Additionally, teaching health systems and hospitals spend approximately \$23.1 billion on physician training annually, but they are reimbursed only Medicare’s “share” of the costs, which is approximately \$5 billion (about 22%). This amounts to over \$18 billion in direct costs not paid for by Medicare.<sup>8</sup> Despite the immense financial pressures teaching hospitals face, AAMC-member teaching health systems and hospitals continue to train above and beyond their caps out of their commitments to their missions and the patients and communities they serve.

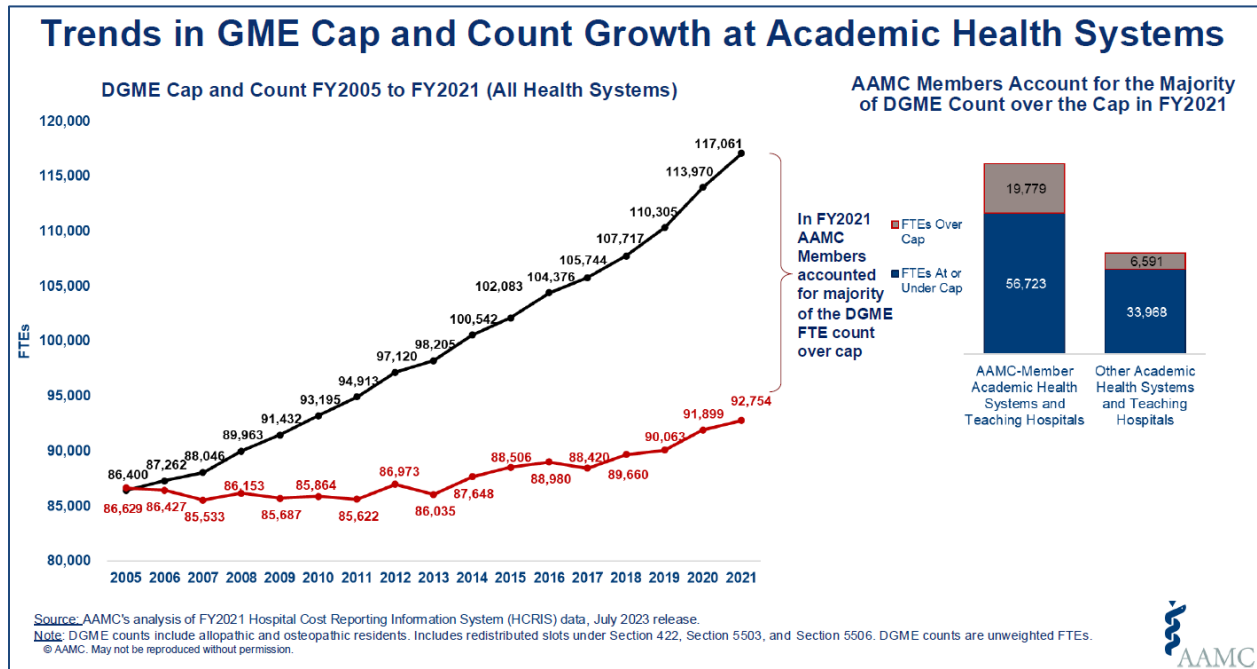


While AAMC-member teaching health systems and hospitals continue to train well above their caps, financial challenges continue to squeeze budgets, making it more difficult to meet the physician training demands they face. A recent analysis of the latest Medicare cost report data for academic health systems indicates that DGME FTE counts have steadily increased year over year, greatly outpacing growth in approved DGME FTE caps. 90% of AAMC member teaching health systems and hospitals are over their caps. Further, 95% of teaching hospitals that were

<sup>7</sup> DGME counts include allopathic and osteopathic residents. Includes redistributed slots under Section 422, Section 5503, and Section 5506. DGME counts are unweighted FTEs.

<sup>8</sup> AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

over their cap by at least 100 full-time equivalent (FTE) positions were AAMC members, training an average of 185 FTEs over the cap. These academic health systems continue to contribute to medical education, scientific and medical research, world-class patient care, and community collaborations and account for the majority of resident FTEs above the cap. This demonstrates the continued commitment that teaching health systems have to their missions.



**To address the disproportionate shortage of primary care doctors and psychiatrists, what percentage of new Medicare GME slots should be dedicated toward these two specialties? What additional Medicare GME policies should Congress consider to encourage more residents to enter these specialties?**

The AAMC cautions against earmarking slots for certain specialties because specialty-specific shortages are not evenly distributed across the U.S., and needs can change over time. While primary care may be in shortage in one area, another area might have an acute need for surgeons or radiologists. Congress should provide local health care leaders and their community partners with the flexibility to determine the appropriate training composition. In fact, the new workforce projections from HRSA cited by the working group note a dearth of vascular surgeons, ophthalmologists, and thoracic surgeons.<sup>9</sup> Prescribing specific numbers or percentages of slots for specific specialties can quickly become outdated due to the shifting market and national or regional needs, thus putting these slots at risk of being less useful before they are even distributed.

<sup>9</sup> Health Workforce Projections, Health Resources and Services Administration, March 2024, available at <https://bhw.hrsa.gov/data-research/projecting-health-workforce-supplydemand#:~:text=Since%20it%20can%20take%20over,overall%20shortage%20of%20139%2C94%20physicians>

Access to both primary care and specialty physicians becomes a more acute need as patients age and their utilization increases. In fact, according to the Medicare Payment Advisory Commission (MedPAC), of those Medicare beneficiaries looking for a new primary care physician, half had difficulty finding one, and of those beneficiaries looking for a new specialist, one-third had difficulty finding one.<sup>10</sup> And because more beneficiaries seek new specialists each year, access to specialists is actually a problem for a larger number of patients. It is clear that there is a strong demand for both primary care specialties and specialist physicians. Those best positioned to make the determinations of the future workforce are those leading teaching health systems and training programs. AAMC-member teaching health systems and hospitals understand the needs of their communities and are best positioned to balance these needs with investments in physician training.

The AAMC encourages the working group to consider Medicare physician payment as a significant obstacle to interest in practicing in primary care specialties. Year after year, physicians must weather cuts or operate under the threat of cuts to their Medicare Part B payments. As the costs of running a practice continue to increase, these Medicare cuts are not only practically untenable but also discourage future physicians from wanting to practice in primary care. In the 2024 Medicare Trustees report, the Trustees expressed concern with the failure of Medicare payments to keep up with the cost of running a practice and warned that they expect beneficiary access to Medicare-participating physicians to become a significant issue in the long term.<sup>11</sup> The AAMC urges the working group to recognize and consider issues outside of the GME program as drivers of these problems.

The AAMC also urges the working group to ensure that any proposal to expand support for physician training does not include counterproductive cuts to teaching health systems and hospitals, including misguided cuts to hospital outpatient departments (HOPDs). It is undeniable that 2023 was a difficult year for our nation's teaching health systems and hospitals, which faced profound financial challenges stemming from historic workforce shortages, unprecedented growth in costs, and significant uncertainty as states resumed Medicaid redeterminations. According to MedPAC, hospitals' overall FFS Medicare margins dropped to a record low - 11.6% in 2022, and this trend is expected to persist in the coming years.<sup>12</sup>

These so-called "site-neutral" payment policies have recently been proposed as a savings mechanism or offsets for legislation. The policies are inherently counterproductive in that they would only further exacerbate financial challenges by cutting Medicare reimbursement for care delivered in HOPDs. The AAMC strenuously opposes these policies, which disregard the real differences between teaching health systems and hospitals' HOPDs and other sites of care, including physician offices and ambulatory surgical centers. As we have emphasized to policymakers, teaching health systems and hospitals' HOPDs care for a more clinically and socially complex patient population than physician offices, while complying with greater

---

<sup>10</sup> MedPAC, Report to Congress, Medicare Payment Policy, Chapter 4 (Mar. 2023).

<sup>11</sup> 2024 Medicare Trustees Report: <https://www.cms.gov/oact/tr/2024>

<sup>12</sup> <https://www.medpac.gov/wp-content/uploads/2023/03/Hospital-Dec-2023-SEC.pdf>

licensing, accreditation, and regulatory requirements. Because of these factors, the cost of providing care in an HOPD is fundamentally different from other settings. Enacting HOPD policies ignores these important distinctions and would result in cuts to Medicare reimbursement for services in off-campus HOPDs.

Proposed HOPD cuts, and in particular, those passed by the House of Representatives in the Lower Costs, More Transparency Act (H.R. 5378), would disproportionately impact AAMC-member teaching health systems and hospitals, many of which are safety-net providers that care for the nation's sickest and under-resourced patients, including in the outpatient setting. Although our members comprise just 5% of all U.S. hospitals, they would shoulder nearly half of the cuts included under the House-passed policy. Given teaching health systems and hospitals' critical role in caring for Medicare's most vulnerable and complex beneficiaries, these proposed cuts would limit these patients' access to life-saving care and cutting-edge treatments. The negative impacts of these cuts would be felt most acutely in rural and other medically underserved communities.

Although significant investments are needed to increase Medicare-supported GME, the AAMC opposes financing these provisions through cuts elsewhere in the Medicare program. As already mentioned, AAMC-member teaching health systems and hospitals are the largest funders of GME and they cannot absorb additional cuts, as it would be impossible to continue their missions of patient care, education, research, and community collaborations. We implore you to reject counterproductive HOPD cuts and avoid the seriously detrimental effect on teaching health systems and hospitals and avert endangering access to care for the patients and communities they serve.

**Would the proposed changes to the definition of rural hospitals in the CAA, 2023 GME allocation formula outlined above improve the distribution of slots to rural communities?**

The CAA, 2023 created 200 new Medicare-supported GME positions, with a requirement that no fewer than 10% be distributed to each of four categories of qualifying hospitals:

- 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).

As part of the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) Final Rule, CMS developed a methodology for assigning priority to applications based on the HPSA score for where residents spent at least 50% of their training. The AAMC and other groups have repeatedly highlighted to CMS that a distribution methodology based only on the prioritization of HPSA scores does not ensure that the statutorily required 10% minimum distribution to each of the four categories of qualifying hospitals is met. The AAMC has strong concerns that this super-prioritization of HPSA score is discouraging applications for slots, and even disadvantaging rural teaching hospitals that are not located in HPSAs.



In distributing the new CAA, 2023 slots, CMS has doubled down on its super-prioritization of HPSA score, despite numerous stakeholder and expert attempts urging them to follow the statutory language more closely. The change that the working group has proposed does not fix the real distribution issue, which is CMS' flawed prioritization process that focuses on HPSA scores to the exclusion of any other considerations or factors. This means that rural teaching hospitals could, in theory, continue to be denied awards and distributions because they have no or low HPSA scores.

The working group has proposed a language change that would, in essence, remove a very specific subset of hospitals "treated as rural" from the slots designated for rural teaching hospitals. This would, in theory, earmark a certain percentage of slots for CMS' defined geographically rural hospitals and certain urban, rural referral centers. However, we will reiterate that unless language is explicitly included to force CMS to abandon its super-prioritization of HPSAs, rural teaching hospitals may still find themselves disadvantaged in the distribution process.

Additionally, we recommend that the working group identify ways to encourage rural teaching hospitals to apply for the slots. While much has been said about the lack of distribution of slots to geographically rural teaching hospitals, the key question about their anemic applications remains unasked and unanswered. In the first round of Sec. 126 distribution, a total of 8 geographically rural teaching hospitals applied, and 5 were awarded slots. In the second round, only 5 applied, and 2 were awarded (one denial was a hospital that received round 1 slots).<sup>13</sup>

It is also critical to illustrate the size of the universe of geographically rural teaching hospitals. The most recent CMS data indicates that there are a total of 82 rural teaching hospitals in the US that are paid under the IPPS (meaning that they are eligible to receive new GME slots under the CAA, 2021 and 2023). Of those, a mere 43 are over their cap. A teaching hospital that has unused cap slots does not need, nor is it eligible, for distributions of Section 126 slots. For perspective, there are about 1150 teaching hospitals in the US, over 800 of which are over the cap. Therefore, another reason for a lack of slot distribution to geographically rural teaching hospitals may in fact simply be that there are not many of them over their caps and willing to take on the added expenses of more residents. We encourage you to consider policies that might enhance the ability of this relatively small universe of eligible rural teaching hospitals to successfully apply for these GME positions and grow their training programs.

**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?**

Yes. As mentioned above, CMS continues to utilize and propose a super-prioritization of HPSA scores in its distribution methodology. This leads to the exclusion of vast numbers of qualifying teaching hospitals that may have low or no HPSA scores. The AAMC strongly urges you to

---

<sup>13</sup> <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/direct-graduate-medical-education-dgme>

include stringent statutory language directing CMS to adhere to the distribution methodology set forth in your potential legislation. The methodology should not be corrupted by CMS' interpretation to the detriment of rural hospitals.

**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?**

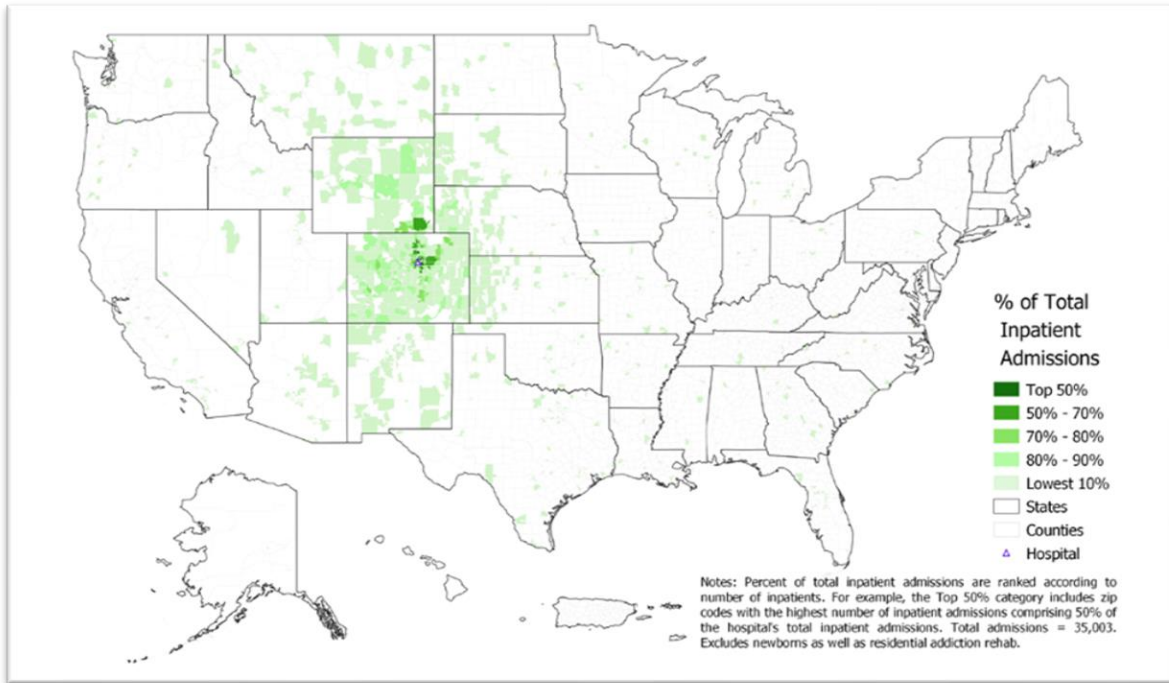
The AAMC does not believe that there is a need to address rural reclassification as it pertains to the distribution of new Medicare-supported GME slots in this proposal. Narrowing the definition of a rural teaching hospital as mentioned above will be sufficient to designate a certain percentage of slots to geographically rural teaching hospitals. Furthermore, an urban hospital's reclassification status does not have an impact on rural teaching hospitals. Rural reclassification does not harm rural hospitals and they are not subject to disadvantages as a result.

Teaching health systems and hospitals in communities throughout the country have relied on rural referral center (RRC) status for close to 40 years. Since the inception of the IPPS, CMS has allowed hospitals to reclassify as an RRC based on a variety of complicated factors. The ability to reclassify is borne out of necessity, and institutions should have the opportunity to reclassify where they meet the statutory and regulatory requirements. Teaching health systems and hospitals may be located physically in urban or suburban areas, but they treat patients from well beyond the bounds of their cities, towns, and even their states. AAMC members treat the most complex patients from rural communities and thus earn their RRC status by virtue of their broad patient population.

The below map showcases the catchment map for UCHealth University of Colorado Hospital, which demonstrates the vast geography of patients admitted to AAMC-member teaching hospitals and health systems.<sup>14</sup> While this is just one example, we encourage the working group to engage with the AAMC so we can further illustrate teaching health systems and hospitals in your states and examine their catchment areas and RRC status to see just how far the reach of teaching health systems and hospitals is.

---

<sup>14</sup> UCHealth University of Colorado Hospital inpatient admissions by zip code of patient residence (July 1, 2020-June 30, 2021).



AAMC members also accept a disproportionate number of transfer cases from surrounding hospitals. A 2019 report found that, despite representing only 7% of hospitals in the analysis, AAMC-member teaching health systems and hospitals treated 40% of transfer cases nationwide – a staggering 13% of their total inpatient case volume. A stark comparison to their non-teaching counterparts, whose transfer case volume hovered at about 3%.<sup>15</sup> Furthermore, the cases transferred to our members have an average case mix index of 2.58, compared with 2.01 at nonteaching hospitals, meaning that AAMC-member teaching health systems and hospitals are also receiving the most complicated cases.<sup>16</sup> Finally, AAMC members are underpaid by \$1,669 more for transfer cases than nontransfer cases.<sup>17</sup>

Taken together, it is clear that teaching health systems and hospitals are earning the RRC designation by the types of patients that they treat from well beyond their cities or towns. The AAMC does not support changing the criteria for RRC status, and Congress must understand the potentially devastating impact teaching hospitals could face if they lose the RRC designation.

Throughout the course of our advocacy on GME and other workforce programs, the AAMC has heard many concerns about the definition of “rural.” CMS defines rural areas based on Core Based Statistical Areas (CBSAs) and generally evaluates county population data to determine if the county is a rural CBSA. According to CMS, “CBSAs are defined by the United States Census Bureau based on work-commuting travel patterns of employed populations. Following the decennial census, the Census Bureau identifies urban areas with a population of at least

<sup>15</sup> <https://www.aamc.org/media/10771/download?attachment>

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

10,000 and groups all counties that contain that urban area with counties in which at least 25% of the population either commutes to or from the core urban area for work.”<sup>18</sup>

Stakeholders have long held that CMS’ definition of rural does not align with other federal agency definitions of “rural” and fellow agencies within the Department of Health and Human Services (HHS) have moved away from using CBSAs alone to determine rurality. For example, HRSA did not agree that CBSAs accurately reflected which communities that participate in health care were rural. In an attempt to refine the definition of rurality, HRSA, informed by the Federal Office of Rural Health Policy, developed its own definition of “rurality” that is much more representative. For many years, the use and purpose of the rural designations by CMS have centered on wage index issues, and GME policy has only been attached because of the Balanced Budget Act of 1997 that capped the number of residency positions at teaching hospitals.

Many institutions that serve rural populations are considered “rural” based on state determinations, or rural patient case mix data and have used RRC status when they are not rural under the CBSA model. Institutions should be allowed the flexibility to reclassify as it makes sense to their community.

**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?**

In the FY 2025 IPPS Proposed Rule, CMS acknowledges that there was a significant lack of applications associated with hospitals whose residents spent at least 50% of their training in a geographic HPSA. Broadening this category of qualifying hospitals to include institutions affiliated with centers of excellence, historically black colleges and universities (HBCUs), minority-serving institutions (MSIs), and located in noncontiguous states would be a meaningful acknowledgment of these institutions’ significant impact in serving traditionally underrepresented communities. The inclusion would also broaden the extremely narrow focus of the HPSA qualifying category and still maintain the category’s focus on serving underserved communities.

The AAMC supports a proposal championed by House Ways and Means Committee Ranking Member Rep. Richie Neal (D-MA) in the 117<sup>th</sup> Congress, the Pathway to Practice Program. This new program would enable medical and postbaccalaureate students from rural and other disadvantaged communities who are underrepresented in the physician workforce to receive support earlier in the medical education pathway and throughout residency training. It would provide scholarships for tuition and other fees to underrepresented and economically disadvantaged students planning to attend medical school, or students participating in postbaccalaureate programs with the intention of applying to medical school. As terms of

---

<sup>18</sup> Everson J, Hollingsworth JM, Adler-Milstein J. Comparing methods of grouping hospitals. *Health Serv Res.* 2019 Oct;54(5):1090-1098. doi: 10.1111/1475-6773.13188. Epub 2019 Jun 13. PMID: 31197825; PMCID: PMC6736907.

participating in the scholarship program, a student would be required to practice a year in a medically underserved area after residency for each year they receive the scholarship.

Scholarship recipients who complete their residency at teaching hospitals with recognition by the Accreditation Council for Graduate Medical Education (ACGME) for certain training activities related to health equity would be exempt from the teaching hospital's GME cap. Importantly, the Pathway to Practice program prioritizes students who attended HBCUs, MSIs, or who participated in HRSA diversity pathway programs. The AAMC urges the working group to engage with the House Ways and Means Committee about this program.

**Would increasing the cap for hospitals in states with the lowest number of GME slots, rather than for all hospitals, improve distribution of GME slots to areas with workforce shortages?**

The AAMC cautions against this approach for a number of reasons, though without additional and/or specific details and definitions on what a state with the "lowest number of GME slots" is, it is hard to generate a thoughtful response. Based on pure slot count alone, the working group risks only opening up new GME slots to smaller states with low populations and few teaching hospitals that can take on additional residents. Additionally, the AAMC cannot support a policy that completely eliminates the ability of some states to receive slots. States like Texas, North Carolina, New Jersey, and others should not be punished for their size (population or geographic) or their teaching health systems and hospitals and communities' investment in physician training. It also ignores the cross-state nature of many teaching health systems and hospitals' patient population and workforce. Many of our members are located close to the border of other states and treat patients from the surrounding area. A state-based policy like this risks punishing those hospitals who may be in a "high GME slot" state but treat patients and employ staff from a "low GME slot" state.

The AAMC does not see a fair way to draw a cutoff as to which states will or will not receive slots. This question is also predicated on the assumption that states with fewer Medicare-supported GME slots have more dire workforce shortages, which is not necessarily the case. As we have noted, teaching health systems and hospitals continue to train above their caps. If the working group proposal were to rely solely on the number of capped Medicare slots in a state, they would be punishing those states that have invested dramatically in supplementing the physician workforce while GME has been frozen. Additionally, this approach would likely make ineligible many of the institutions with the necessary training infrastructure and patient populations necessary to effectively and efficiently train more physicians.

If the concern is ensuring that states with fewer GME positions are prioritized, the AAMC suggests possibly creating a distribution preference in which 10% of slots are designated for states with low medical resident FTE-to-bed ratios. However, we further emphasize that this carve-out is meaningless without explicit instruction to CMS that it must follow the proposed distribution methodology.

## **How can Congress help incentivize Medicare GME in Indian Health Service Facilities?**

Acknowledging the need for training opportunities at tribal and IHS facilities, the Department of Veterans Affairs has established a limited reimbursement program for training that takes place at IHS facilities. As part of the Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018 (VA MISSION, P.L. 115-182), the Pilot Program on Graduate Medical Education and Residency (PPGMER) will fund no fewer than 100 residents to train at non-VA facilities, a first for the department. Additionally, the VA MISSION Act allows the VA to provide funding associated with the startup costs for new residency programs. Eligible facilities, or “covered facilities,” include those operated by an Indian tribe or tribal organization, the Indian Health Service, a Federally Qualified Health Center (FQHC), a health care facility operated by the Department of Defense, or other health care facilities the VA considers appropriate for the purposes of the PPGMER.

The PPGMER will sunset on Aug. 7, 2031. The positions and programs created under the PPGMER could be a beachhead for further IHS GME development, but the long-term success of training at these sites requires permanent and sustained financial support. There is significant interest from stakeholders in developing IHS GME, but to be truly sustainable, the work must move to a proven GME reimbursement model.

Congress could enact legislation to consider time spent at IHS hospitals as time spent at “non-provider sites,” similar to Critical Access Hospitals. This would allow facilities to continue the development initiated through the PPGMER and encourage opportunities for residency training by fostering necessary educational partnerships with academic health systems.

### **SECTION 3. Encouraging Hospitals to Train Physicians in Rural Areas**

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

The AAMC strongly supports ensuring access to care in rural areas, and expanded training opportunities. We recently participated in a rural day of action, which highlighted the efforts in which our members have engaged to deliver care in rural communities and train the next generation of rural providers. While additional physician training programs and increased Medicare support for GME are fundamental to addressing the physician shortage, it is simply not enough to provide the opportunity for additional GME slots. Training programs require significant start-up funding and sustained resources to support the underlying costs of training including: undergoing accreditation, employing supervisory staff, securing necessary equipment, and setting up new administrative and evaluation functions.<sup>19</sup> For these reasons, new training programs cost millions of dollars and take many years to establish – resources that already overextended rural hospitals generally do not have. Furthermore, as mentioned earlier, Medicare only pays *its share* of training costs – meaning that rural and underserved hospitals will still only

---

<sup>19</sup> <https://www.aamc.org/data-reports/faculty-institutions/report/becoming-teaching-hospital-guide-medicare-requirements>

recoup a fraction of the costs – about 22% – of training residents, and that is only *after* the residents are on the ground training.<sup>20</sup> For rural hospitals already operating on tight budgets, this can be an insurmountable barrier to starting new programs or increasing existing ones. Residents must also have access to sufficient patient volume in order to complete their training. For example, to complete their training in family medicine, a resident must have 1,650 patient continuity encounters.<sup>21</sup> This means that *every resident* must complete this requirement, and therefore, all residents must have access to the requisite volume of patients needed to satisfy this requirement.

The federal government invests in a myriad of incentives to increase training in rural areas. Rural teaching hospitals enjoy several advantages that urban teaching hospitals cannot. For example, unlike other teaching hospitals for which Medicare support has been limited at 1996 levels since 1997, the “caps” for rural hospitals were set at 130 % of their 1996 levels, leaving them significant room to grow their training programs.<sup>22</sup> The Medicare program also allows rural hospitals to expand their cap when they add a new medical residency program.<sup>23,24</sup> In other words, a rural hospital can add a new residency training program at any time and receive additional Medicare support for the new trainees, while Medicare support for other hospitals is bound by the caps established nearly three decades ago. Similarly, Medicare caps do not apply to CAHs; these hospitals can expand existing programs or add new programs without limit and will continue to receive Medicare support for 101% of their reasonable costs.

Finally, investments in physician training programs alone cannot be expected to overcome the numerous other factors that influence a graduate’s final practice location. Efforts to improve physician distribution cannot rely solely on educational interventions but rather should prioritize the types of strategies that have demonstrated effectiveness, such as financial incentives to practice in underserved areas. When surveyed, medical students graduating medical school indicate that choice of specialty is influenced by a variety of factors including lifestyle, skills and interests, and work/life balance.<sup>25</sup> Another important factor influencing the location choice of married students, in particular, is whether their spouse will be able to find employment in the area.<sup>26</sup> Physicians, like the rest of us, want to build lives and futures for their families. This means that the opportunities presented to them must appear to be viable for themselves and their families. Rural communities face many challenges, and to make rural residencies more attractive, we must invest more in rural communities and their infrastructure.

---

<sup>20</sup> AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

<sup>21</sup> Dickson GM, Jarvis JW, Pickeral L. IN PURSUIT OF 1,650. *Ann Fam Med*. 2016 Sep;14(5):480–1. doi: 10.1370/afm.1986. PMID: PMC5394373.

<sup>22</sup> 42 U.S.C. 1395ww(d)(5)(B)(v)

<sup>23</sup> 42 U.S.C. 1395ww(h)(4)(H)(i)

<sup>24</sup> 42 C.F.R. 413.79(e)

<sup>25</sup> <https://www.aamc.org/download/498790/data/2019ggallschoolsummaryreport.pdf>

<sup>26</sup> <https://jamanetwork.com/journals/jama/fullarticle/2733664>

**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?**

Stakeholders often confuse the distinct purposes of Medicare DGME payments and indirect medical education (IME) payments, perhaps because they both are labeled “education” payments despite their differing purposes. As noted in the proposal, and stated earlier, DGME payments cover training expenses such as resident stipends and benefits, faculty salaries and benefits, and allocated institutional overhead costs. Most teaching settings, including many federally qualified health centers (FQHCs) and rural health clinics (RHCs), are currently eligible for DGME payments. Like teaching hospitals, those payments would be calculated based on the facility’s Medicare share.

Medicare IME, on the other hand, constitutes a patient care payment designed to partially offset the unique costs associated with caring for highly complex, severely ill inpatients at teaching hospitals. Unlike DGME payments, IME payments are provided as add-on payments for patient care services on a per-Medicare-beneficiary-discharge basis. Thus, IME payments attempt to remedy a flaw in the diagnosis-related group (DRG)-based prospective payment system (PPS), which does not capture these unique additional expenses teaching hospitals incur by providing round-the-clock access to highly specialized and costly patient care resources in a wide range of services. While other entities may treat challenging patient populations, they do not provide the level of complex care or stand-by capacity provided by teaching hospitals, and their Medicare and Medicaid reimbursement is often cost-based; consequently, they do not suffer the payment shortfalls that the IME is intended to resolve.

This intent for IME payments is clearly stated in House and Senate report language from when Congress explicitly created the adjustment for teaching hospitals as part of Medicare’s DRG-based PPS:

**This adjustment is provided in light of doubts ... about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.<sup>27</sup>**

Disregarding the original intent behind the IME payment and using it for a new purpose would have major implications for the patients who seek stand-by and other unique regional services at AAMC-member teaching hospitals. Compared with physician offices and other hospitals, major teaching hospitals care for patients who are sicker, poorer, and more likely to be disabled or non-white.

---

<sup>27</sup> House Ways & Means Committee Rept. No. 98-25, March 4, 1983, and Senate Finance Committee Rept. No. 98-23, March 11, 1983



**What programs under the jurisdiction of the Senate Finance Committee can provide targeted outreach and technical assistance to rural hospitals so they can apply for Medicare GME slots?**

The AAMC urges the working group to partner with CMS to further publicize the application announcements for the new GME slots. We believe that additional publicity and perhaps additional lead time before the application process opens would be helpful for those teaching hospitals that may not be as well-resourced, or may need extra time to gather their application materials. The AAMC also encourages the working group to engage with rural teaching hospitals and specifically ask them what would be helpful for them. While we frequently hear from large, national organizations about a desire to see more slots go to rural teaching hospitals, we have not yet seen a rural teaching hospital that was over its cap explain why it did not apply for these positions. We expect and support your work to engage with these institutions to better determine their needs as part of this process.

**Should guardrails be put in place to ensure patient outcomes and a resident's educational experience are not negatively impacted by an extension of flexibilities that allow teaching physicians to use telehealth to train resident physicians?**

The AAMC strongly supports continuing certain pandemic-era flexibilities into the future. We appreciate that CMS finalized a policy to permanently allow for the virtual supervision of residents in rural areas for both telehealth and in-person services. This will allow better access to care and increase training opportunities. We also appreciate the extension of virtual supervision of residents for telehealth services in urban areas through December 31, 2024. With the policies in effect, residents have been virtually supervised safely and effectively for both in-person and telehealth services. We urge CMS to permanently allow for virtual supervision of residents for both telehealth and certain in-person services in all regions of the country.

Existing guardrails generally require real-time observation (not mere availability) by the teaching physician through audio/video technology during the key or critical part of the service. In order for the teaching physician to satisfy supervision requirements virtually and receive payment for resident services, the medical record must include documentation of how and when the teaching physician was present during the key or critical portion of the services. CMS' policy excludes certain services from the virtual supervision policy that it believes require a level of oversight that a teaching physician could not meet virtually, including surgical, high-risk, interventional, endoscopic, or other complex procedures and anesthesia services. Medicare reimburses teaching physicians for services rendered by residents so long as the teaching physician provides the required level of supervision of the resident. Medicare does not reimburse residents directly for services rendered.

Guardrails also exist through the Accreditation Council for Graduate Medical Education (ACGME)<sup>28</sup> and other accrediting organizations that have standards and systems that will ensure patient safety and oversight of residents when virtual supervision of residents occurs. ACGME

---

<sup>28</sup> See ACGME program requirements (common program requirements residency)

sets forth extensive program requirements, including requirements related to supervision. ACGME recognizes that supervision may be exercised through a variety of methods, as appropriate to the situation, including through telecommunication technology. The program must demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability guided by milestones, as well as patient complexity and acuity. The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. Teaching physicians are ultimately responsible for determining the level of supervision required and any adverse events that occur.

AAMC believes that the current guardrails implemented by CMS, ACGME, and other accrediting organizations are sufficient to ensure patient outcomes and a quality educational experience for the residents. These entities and the medical education community at large work to monitor, report, and address any issues related to workload, patient safety, medical error, resident well-being and burn-out, professionalism, and resident learning and outcomes. Teaching physicians also use their professional judgment to identify any additional instances in which virtual supervision is not appropriate. Ultimately, billing only occurs under the teaching physician; therefore, the teaching physician is responsible for ensuring that all services are appropriately furnished.

**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?**

AAMC commends Congress for passing an initial extension of crucial telehealth waivers until Dec. 31, 2024, as well as for providing permanent coverage and payment of telehealth mental health services. The AAMC recommends that Congress permanently remove the geographic restriction and add the home as an originating site. These policies allow patients to remain in their homes, reducing their exposure to viruses, as well as ensuring that patients who find travel to an in-person appointment challenging can receive care. This is particularly important for patients with chronic conditions or disabilities who need regular monitoring. It also helps those who, because of their job, lack of care for dependents, transportation issues, and other limitations, find it difficult to attend an in-person visit to receive care.

As part of their training, it is essential for residents to have experience with providing telehealth visits while supervised as they will be providing them in the future to their patients when they practice independently. To further improve access to care and provide enhanced training opportunities for residents, particularly those training in rural and underserved areas, Congress should make the telehealth COVID-19 flexibilities and waivers permanent. At a minimum, the AAMC recommends a two-year extension to allow for additional time to collect data and promote continuity of care.

During the COVID-19 public health emergency (PHE), the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) established Medicare payment for telehealth services when

rural health clinics (RHCs) and FQHCs serve as the distant site. RHCs and FQHCs were able to effectively furnish telehealth services and treat patients via telehealth during the PHE and should be allowed to continue to do so. If FQHCs and RHCs are no longer able to furnish telehealth services to patients after December 31, 2024, this will limit access to care, which may negatively impact patient health. Residents will also lose critical training opportunities. We encourage Congress to pass legislation to permanently continue payment for telehealth services furnished by FQHCs and RHCs.

**What additional incentives could be provided to hospitals to partner with rural hospitals or ambulatory care facilities to establish residency programs supported by Medicare GME?**

The limitation on rural GME development continues to be the lack of infrastructure necessary to sustain residency training programs. For many hospitals, meeting the 50% training requirement for a rural track program (RTP) can range from difficult to impossible, depending on the rural training opportunities within the community. The AAMC would point to certain specialties like obstetrics and gynecology, and surgery that are in great need in rural communities but have difficulty meeting accreditation requirements with the RTP 50% requirement. The committee could explore a new type of RTP that builds on the strengths of Section 127 of the CAA, 2021, while allowing hospitals more flexibility in developing rural training opportunities.

**How can existing rural track programs be strengthened and expanded through Medicare GME?**

The significant changes to the RTP through Section 127 of the CAA, 2021 greatly increased the utility and appeal of the program. RTPs represent an important development for rural training, capitalizing on the strengths of urban academic medical centers, and rural clinical training sites. Two potential prospective policy changes would be to (1) allow RTPs with established RTP caps prior to October 1, 2022 a new cap building window, which would allow for the expansion of proven rural training programs, or (2) to remove RTP residents altogether from a hospital's GME cap.

The limitation on the development of RTPs has to do primarily with the infrastructure necessary to participate in GME training. RTPs must have the faculty and program staff necessary to meet accreditation requirements. The clinical environment must also provide the necessary training opportunities for residents. In many cases, these limitations inhibit the development of new RTPs.

#### **SECTION 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage**

**Should Congress include additional specifications for a GME Policy Council in order to improve its success in allocating GME slots to physician specialties projected to be in shortage?**

The AAMC does not believe that the creation of such a council constitutes wise deployment of already limited federal resources. GME slots are not allocated based on specialty but for an exception made in the CAA, 2023, and as stated above, we do not believe that it is wise to mandate that some slots go to specific specialties due to the changing nature of the US population and its patients' needs.

**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?**

COGME, a body convened by HRSA and authorized under the Public Health Service Act,<sup>29</sup> is intended to provide recommendations to the HHS Secretary and Congress on the physician workforce. It has regularly made these reports since its inception in 1986. COGME has specific expertise that has been key in developing programs with high impacts on rural communities. Specifically, advocating for the HRSA-administered Teaching Health Center Graduate Medical Education (THCGME) Program and rural residency programs, COGME has fostered stakeholder communities in rural and underserved areas. While these are critical areas of workforce development, Congress could direct COGME to expand beyond its traditional rural and primary care focus areas to include input on GME issues that affect a broader array of underserved communities and issues important to major academic health systems.

#### **SECTION 5. Improvements to Medicare GME Treatment of Hospitals Establishing New Medical Residency Training Programs**

**How much time do hospitals with low GME caps need to reset their caps?**

Artificially low or zero per resident amounts (PRAs) and low FTE caps are a persistent issue that the AAMC is supportive of fixing. Because of CMS' policies regarding when the cap building window starts or when a hospital sets a PRA, many non-teaching hospitals inadvertently set low FTE caps or PRAs. A common scenario for many of these hospitals is that they accepted a single resident rotator or small group of resident rotators for a limited amount of time, without the intent to create training programs of their own. Generally, these residents came from new teaching hospitals or established teaching hospitals where residents would come in for educational rotations and leave after completing a distinct rotation or set of rotations.

---

<sup>29</sup> 42 U.S.C. § 294o

Congress took action in Section 131 of the CAA, 2021, which allowed certain hospitals to reset low or zero PRAs or low full-time equivalent FTE caps. CMS proposed two categories of hospitals eligible for a reset:

- Category A hospitals would have set a low or zero PRA or FTE cap as the result of less than 1.0 FTE in any cost reporting period beginning before October 1, 1997.
- Category B hospitals would have set a low or zero PRA or FTE cap with 3.0 or fewer FTEs in any cost reporting period beginning on or after October 1, 1997, but prior to December 27, 2020. A hospital that reflects the requisite number of FTEs on any cost report beginning on or after December 27, 2020, and December 26, 2025, would be eligible for a reset.

For many years, hospitals that met the Category A or B criteria were essentially locked out of expanding residency training because of the restriction on the amount of Medicare GME reimbursement, either through low FTE caps, a low PRA, or both. Section 131 was a lifeline for the hospitals that are eligible to take advantage of this program. However, the AAMC would flag two significant impediments in the Section 131 legislation that have reduced the effectiveness of this program:

- The limited window to meet the requisite number of residents to trigger a new FTE cap-building period, or PRA reset; and
- The narrow FTE counts for Category A or B.

The AAMC believes that the legislatively mandated time restriction for hospitals to take advantage of these reset programs makes it difficult to start new training programs. The Government Accountability Office (GAO) found that “[h]ospitals starting their first GME training program spend an estimated \$2 million to \$8 million over 3 to 7 years to establish GME programs, according to information from hospital representatives.”<sup>30</sup> Because developing new programs takes a significant amount of time and resources, some institutions were not ready to take full advantage of Section 131. Congress should either extend the program to allow institutions time to properly develop new residency programs (possibly for 10 years beyond 2025) or remove the time limitation altogether and give hospitals that meet Category A or Category B criteria the ability to start training residents and build a new cap or PRA when they are ready.

Additionally, the AAMC has heard from hospitals and academic health systems that would like to expand residency training at hospitals with artificially low FTE counts or PRAs, but they do not meet Category A or B qualifications. For instance, if a hospital that established its FTE cap as of Dec. 31, 1996, with 1.0 FTE instead of less than 1.0 FTE, it would be barred from a reset, even though this institution was clearly negatively impacted by the same CMS policy as the hospital that qualifies for a reset. Congress could have a significant impact if it increased the Category A and B FTE qualifying criteria to 10 or fewer FTEs.

Congress should expand this program to include hospitals that can demonstrate that they have

---

<sup>30</sup> Physician Workforce Caps on Medicare-Funded Graduate Medical Education at Teaching Hospitals, Government Accountability Office Report to Congress, May 2021.

not trained residents in the preceding 5 cost reporting periods; they should be eligible to build a new FTE cap or reset their PRA regardless of the number of FTEs trained.

**Should additional hospitals be eligible to reset their low GME caps? What should be the eligibility criteria of these additional hospitals?**

Yes, the AAMC is supportive of allowing additional hospitals to reset their low GME caps. The AAMC recommends that Congress remove the window of time for which hospitals may take advantage of this program. Prospectively, any hospital that meets the Section 131 qualifying Category A or B criteria should be eligible to take advantage of resets. Additionally, Congress should expand this program to include hospitals that can demonstrate that they have not trained residents in the preceding 5 cost reporting periods; they should be eligible to build a new FTE cap or reset their PRA regardless of the number of FTEs trained.

**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?**

It is unclear what the tangible benefits of this section would be when practically applied to teaching hospital closures. The AAMC is concerned that the potential goal of this provision stands to be outweighed by the potential downside to small and rural hospitals, and regions of the country that have shortages. The purpose of the “regional” category in Sec. 5506 of the Affordable Care Act (ACA) is to recognize that shortages do not stop at state borders, and teaching health systems and hospitals treat patients and employ physicians from across state lines.

Section 5506 allows CMS to redistribute residency positions from closed teaching hospitals through an application and award process. When CMS provides public notice, institutions have 90 days to respond. The application for awards considers different factors but prioritizes applications based on geographic closeness to the closing hospital:

1. First priority goes to hospitals within the same CBSA;
2. Second to hospitals within the same state;
3. Third to hospitals within the same region (but may cross state boundaries);
4. If there are any unawarded positions, those remaining will go through the Section 5503 redistribution process that considers different factors than Section 5506.<sup>31</sup>

Beyond geographic priority, CMS gives a significant amount of consideration to teaching hospitals that take in residency programs in their entirety from closed teaching hospitals, and teaching hospitals that take in residents from closed programs (but not a transfer of an entire

---

<sup>31</sup> 1886(4)(H)(vi)(II)

program).

This distribution process was intentionally designed to ensure that the ripple effect of a hospital closure would not eviscerate the training opportunities in a specific state or region. As you can see, it was designed to move outward from ground zero of the hospital closure, keeping the slots as close to the hospital and community as possible. The proposed changes would keep CBSA and state prioritization but remove the regional geographic prioritization. This is an important prioritization consideration, as this helps protect the physician workforce and maintain access to care in the areas that are impacted by the closure of a teaching hospital.

The effect of this proposal is to move redistributions out of the geographic area, under the prioritization of factors for another redistribution program from the ACA, Section 5503. Under Section 5503, priority goes to hospitals in states with the lowest quartile of medical resident-to-population ratio, and next to the 10 states with the highest ratio of geographic HPSA population to total population, and last to hospitals located in a rural area as determined by 1886(d)(2)(D)(ii).<sup>32</sup> This could mean, for example, that slots from a closed Colorado (or Texas, New Jersey, Tennessee, North Carolina, or Louisiana) hospital could potentially be diverted to a hospital in Mississippi. While Colorado has a better resident-to-population ratio than Mississippi, one could see how the loss of GME slots in that state that were not absorbed into teaching hospitals in the immediate region could dramatically impact care for Coloradans.

Since the adoption of the provision, CMS has awarded positions through 20 rounds of 5506 distributions for closed teaching hospitals and has issued notice for 22 rounds. Broadly generalizing the distribution of slots through the program, the vast majority are awarded to hospitals within the same CBSA or state, relative to the total number of positions awarded to hospitals within the region. The AAMC believes that the workforce development in a region benefits from the resident slots staying close in geographic proximity to the closed hospital, and because this change would have a very low impact on the number of positions redistributed through the alternative distribution methodology, this proposal would likely have limited application.

The proposed legislation also modifies a portion of the application for Section 5506 that in part has become a fixture of legislation authorizing the redistribution, or award of new residency positions. The demonstrated likelihood criteria for Section 5506 requires hospitals to demonstrate that they have the capacity to increase the number of residents trained by the number of positions awarded. For Section 5506, the demonstrated likelihood for hospitals is 3 years.

---

<sup>32</sup> (i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary). “(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of— “(I) the total population of the State, territory, or District living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to “(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census). “(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

The proposed demonstrated likelihood criteria would incorporate a new requirement that hospitals demonstrate a likelihood of “starting to utilize the positions made available under this section within 2 years.” While moving the window from 3 to 5 years might have limited benefit to institutions, it’s not readily clear what the demonstrated “utilization” requirement adds beyond the current demonstrated likelihood criteria. The intent of this legislation appears to motivate hospitals to utilize awards within 2 years. This could have a significant negative impact on institutions as teaching hospitals generally phase in new residency positions over several years. Typically, this would be the minimum number of years to be board-eligible in the program specialty. If a hospital applies for and is awarded 6 FTE positions through Section 5506 distributions in an internal medicine program, the program will generally phase in utilizing the slots one per year over three years, or the minimum number of years necessary to be board eligible in internal medicine. This is because residency training is longitudinal, and takes place over several years. When hospitals match a new Post Graduate Year (PGY) 1, they will have to “backfill” that position in the following year when the PGY 1 becomes a PGY 2. This means that, depending on specialty, hospitals might take up to five years to “utilize” positions awarded.

At best this is redundant legislation because the current demonstrated likelihood criteria ensure that hospitals have a plan for utilizing any award, but this requirement could also have unintended negative consequences.

**What additional policies should Congress consider to improve the distribution of unused GME slots to areas facing the greatest projected shortage of physicians?**

The AAMC is unclear on what constitutes an “unused” GME slot. As stated earlier, most teaching hospitals are operating extremely close, at, or over their Medicare GME caps. Teaching health systems and hospitals are incentivized to keep their GME slots filled, and generally speaking, if they are not filled at any given moment there is a reason. According to the AAMC’s data, of the approximately 1,150 teaching hospitals in the US, only 110 have, for 3 years, had “unfilled” slots, and 68 of those hospitals had fewer than 5 “unfilled” slots over the course of the 3-year average. Most of the hospitals are small, or medium-sized, and 13 of them are geographically rural. We do not know why these hospitals are below their caps, and these slots could easily be temporarily unfilled due to program needs and funding constraints.

This policy stands to divert slots from hospitals in states like North Carolina, Texas, Tennessee, and New Jersey to other regions of the country. As we have noted before, every state has a physician shortage. Diverting slots from one hospital to another does not solve the problem that there simply are not enough GME slots to go around. Furthermore, the AAMC is uncomfortable with the proposition of punishing states and communities who invested in teaching hospitals by confiscating their slots, when any non-teaching hospital at any point can establish a teaching program and begin training. The AAMC urges the working group to look more critically at the lack of new teaching hospitals in states with severe shortages. A more appropriate approach would be incentivizing non-teaching hospitals and their community stakeholders to establish new



teaching hospitals which, as mentioned earlier, are eligible to start new programs and not be subject to a cap until their cap-building window is closed.

## **SECTION 7. Improving GME Data Collection and Transparency**

### **What information do teaching hospitals already report on the “outcomes” of their residency programs, and where is this information reported?**

A better understanding of what “outcomes” means would be necessary to fully address this question. Generally, the accrediting body tracks residency program completion (ACGME, Commission on Dental Accreditation, Council on Podiatric Medical Education). This is determined at the program level, and the program operates under a sponsoring institution, which may or may not be the hospital that residents rotate to. Individual resident data is collected through the Interns and Residents Information System (IRIS) reporting software, which tracks resident time spent training in a hospital or in a non-provider site but is separate and distinct from data kept regarding program completion.

Creating a legislative requirement that hospitals provide “outcomes” data would be extremely difficult because a hospital that captures the resident's time may or may not be the “home hospital” for the residents. It is common, and encouraged by ACGME, for residents to complete rotations at several different institutions during their training programs. Tracking the outcomes of residents at the hospital level, and reporting that information to Congress would be a significant administrative burden. Additionally, this would be duplicative between information that is required by the accrediting body and information for the CMS cost report. Much of the information requested is available, and creating another reporting requirement is unnecessary.

### **What additional information should teaching hospitals report, in addition to what is proposed above, in order to improve accountability of federal GME investments?**

Teaching hospitals spend hundreds of hours and thousands of dollars reporting on their GME programs, and Medicare cost reports contain a wealth of information on how teaching hospitals deploy their Medicare GME funds. We strongly caution the working group against mandating duplicative and unnecessary reporting requirements on teaching hospitals, who are already struggling with overly burdensome reporting requirements throughout the federal programs in which they participate.

The working group has recommended that the following information be reported:

*The number, specialty type, diversity, and citizenship information of residents supported and who completed their residency under each federal GME program.*

Most of this information is already reported to ACGME. Additionally, the AAMC is unsure if this information will be helpful, as taking stock only of Medicare-supported residency information does not paint a complete picture of a teaching hospital's residency population.

*The amount of Medicare direct GME (DGME), including the per resident amounts, and indirect*

*medical education (IME) payment that a teaching hospital receives.*

This information is already reported and available on the Medicare cost report.

*The amount that a teaching hospital spends on training residents, including through direct costs like resident stipends and supervising physician salaries, and indirect costs, broken down by each year of a resident's training.*

Information on resident stipends is available on the cost report. Supervision physician salaries are private, proprietary information that should not be publicly disclosed for anti-trust and anti-competitive reasons. Breaking this information down by each year of training is also enormously burdensome and ultimately unhelpful due to the number of rotations that residents do between departments and training sites.

*The number and percentage of residents by specialty type who completed their residency and entered practice in a HPSA or rural area.*

It is unreasonable to expect teaching health systems and hospitals be held responsible for collecting and reporting the professional, career, and personal decisions of former residents and trainees.

*The number and percentage of residents retained in the practice of primary care at least two years after the completion of their residency.*

Teaching health systems and hospitals do not track this information and it would be enormously burdensome for them to keep track of the practice status of every single resident that they train. Similar data to this is available from the American Medical Association.

*The amount of GME payment, broken out by DGME and IME payment amounts, provided by residency type or specialty and site of training.*

While teaching hospitals' DGME and IME payment totals are included on the cost report, this level of detail is simply not possible. While proposals often wish to "paint the money red," they disregard how hospital reimbursement and budgeting function. Asking a teaching hospital to break out a payment by residency type or site of training is akin to asking a head of household to indicate which dollar of their paycheck went to which grocery items they purchased or what bill they paid. Teaching hospitals navigate a complex reimbursement system and must manage countless payments from federal sources simply to remain in operation, and to ask them to account for every dollar in this way is impractical and burdensome.

*The number of residents who experienced remediation, probation, transfers, withdrawals, or dismissals, broken out based on gender and race or ethnicity.*

The AAMC is unclear on the utility of this information for the purposes of administering Medicare GME funding.

**What additional data does Congress need to collect in order to determine whether DGME and IME payment rates appropriately match the cost of training residents? For example, what data does Congress need in order to determine whether payment rates for GME funding be calculated by methods that are not focused on Medicare beneficiary inpatient bed-days?**

The public has entrusted recipients of federal resources to be accountable; there is no more central measure of accountability than to remain true to the intent of the funding, and there is no more central intent of Medicare funding than to serve Medicare beneficiaries. AAMC-member teaching health systems and hospitals and their faculty physicians care for a disproportionate number of Medicare beneficiaries and divorcing that connection and restructuring the Medicare GME payment methodology dismisses this core objective and would undermine the Medicare program by relegating it to being a mere funding source. The AAMC believes the current distribution of Medicare funding on the basis of an institution's Medicare volume is the appropriate methodology.

A tremendous amount of data on the direct costs of residency training are already collected and the information is available on a teaching hospital's cost report. Creating additional reporting requirements to Congress would be redundant and unnecessary.

The Medicare cost report captures the direct costs of training residents as factored into the DGME payment's PRA. The cost information is not associated with Medicare beneficiaries until Medicare applies the "Medicare share" factor to the DGME payment calculation. The Medicare share factor is determined by the number of Medicare inpatient days to the total inpatient days but is distinct from the cost reporting information for the PRA. In essence, the direct costs are already reflected on the CMS cost report.

Again, we must emphasize that IME payments are patient care payments, not education or training payments. Congress understood that there were substantial patient care costs borne by teaching institutions that could not be accounted for through cost report data. Since the inception of the IPPS, Congress acknowledged these additional patient care costs by providing teaching hospitals with (the misnamed) Indirect Medical Education or IME adjustment, which is added to each Medicare discharge. By nature, these additional patient care costs are hard to define as they reimburse hospitals for the higher acuity of patients, standby capacity, burn units, etc.

**It is of interest to track whether residents trained in primary care continue to practice in this specialty because primary care training is frequently a precursor to other residency training. Are there other specialties that teaching hospitals should similarly report?**

Teaching health systems and hospitals should not be required to report this information. The ACGME captures information regarding which residents complete programs, not the hospital's Medicare reimbursement department. Additionally, tracking the residents at the hospital level would create significant administrative burdens. Teaching hospitals will accept many residents

for a single rotation, or a few rotations. Resident FTEs are fungible, meaning that the Medicare FTE count for a hospital can be made up of (and is most likely) residents from other teaching hospitals. Creating a legislative requirement that hospitals track all the residents that they capture on the cost report would be exceedingly difficult, and unnecessary.

\*\*\*\*\*

Thank you for the opportunity to provide feedback on this draft proposal. The AAMC is happy to continue engaging with the working group on this and future iterations of this crucial policy. If you have any additional questions, please reach out to Len Marquez, AAMC senior director, of government relations and legislative advocacy ([lmarquez@aamc.org](mailto:lmarquez@aamc.org)).

Sincerely,

A handwritten signature in black ink that reads "Danielle P. Turnipseed". The signature is written in a cursive, flowing style.

Danielle Turnipseed, JD, MHSA, MPP  
Chief Public Policy Officer  
Association of American Medical Colleges

CC: David J. Skorton, MD  
President and CEO  
Association of American Medical Colleges