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January 27, 2025

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

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

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

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

Dear Senators Cassidy, Cortez Masto, Cornyn, and Bennet:

The Association of American Medical Colleges (AAMC) is pleased to provide feedback on the draft legislation proposed as part of your bipartisan efforts to expand the physician workforce. We commend your continued efforts and dedication to improving patient access to care by expanding and enhancing Medicare-supported graduate medical education (GME). The AAMC is eager to collaborate with you further as this legislation evolves. The physician workforce is one of our key policy priorities, and we have a tremendous amount of data, research, and experience to offer when considering how to strengthen and expand the physician workforce.

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 159 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; nearly 500 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 201,000 full-time faculty members, 97,000 medical students, 158,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers International broadened participation in the AAMC by 70 international academic health centers throughout five regional offices across the globe.

The AAMC is pleased that you are continuing the work started by the bipartisan working group that formed in the Senate Finance Committee during the 118th Congress. We applaud you for your engagement with stakeholders and are pleased to see many AAMC-supported provisions in the draft bill. Your collaborative, bipartisan approach to policymaking is laudable, and we look forward to continuing to partner with you and your staff.

We appreciate the opportunity to provide feedback on the draft, and submit the following responses to the questions you have proposed for consideration:

1. Is the 30-slot cap appropriate for ensuring fair distribution of residency slots across hospitals? What other strategies could Congress consider to ensure hospitals in all regions have an equal opportunity to compete for slots?

30-slot Cap for the Distribution of New Slots
The AAMC believes that a cap of 30 slots per teaching hospital would help provide a wide distribution of resident full-time equivalent (FTE) positions. We also support the provision that, should all positions not be distributed, the Centers for Medicare and Medicaid Services (CMS) would be required to conduct additional distribution rounds until all positions are awarded. We must ensure that all available positions are allocated, as this will help address the projected physician shortage the nation faces.

Residency training generally takes between three to five years (and sometimes longer) and policymakers should consider that to fully fund the training of one physician, and continue a full complement increase, a program could need up to three to five FTEs. Therefore, we would support the implementation of a five-slot "floor," unless a program has applied for fewer than five slots. The primary goal should be ensuring that programs receive enough slots to build meaningful increases in training programs. We have seen tremendous demand for the slots currently being distributed as part of Section 126 of the Consolidated Appropriations Act (CAA), 2021, and while we remain grateful for this increase, many teaching hospitals are receiving fractions of slots. We believe that setting a "floor" would ensure that qualifying teaching hospitals can meaningfully expand their programs.

Number of Slots Provided by the Bill
The proposed increase of 5,000 slots, while significant, is not sufficient to meet the needs of the growing and aging US population. As you know, Medicare-supported GME has been effectively frozen since 1997, but for two recent increases over the past nearly 30 years totaling 1,200 slots provided by Congress in the CAA, 2021 and 2023. This means that as population demographics have shifted over a quarter of a century, Medicare-supported GME has largely remained stagnant, and a large infusion of slots is needed to ensure adequate geographic distribution. Further, we have seen significant interest in applying for the Section 126 slots, which are sought by hundreds of teaching hospitals in each round. The AAMC encourages you to increase the number of slots provided in the bill to 10,000.

Ensuring Widespread Distribution of Slots
The AAMC is pleased to see Sec. 3 (c) PROVIDING OUTREACH AND TECHNICAL ASSISTANCE TO RURAL HOSPITALS REGARDING AVAILABILITY OF MEDICARE GRADUATE MEDICAL EDUCATION PAYMENTS. We have consistently raised concerns that rural hospitals are not getting the technical assistance they may need to start rural training programs. There are myriad federal programs specifically targeted to rural training, and key existing advantages for rural teaching hospitals that we believe would be more heavily utilized

with appropriate assistance. We are grateful to the working group for acknowledging this and providing this assistance through a mandatory appropriation.

While we appreciate the focus on assisting rural teaching hospitals in expanding their training, we are concerned that the proposed grants to states for assisting with specific distribution programs (like the 5,000 slots made available in this draft legislation) may not be as impactful as codifying or investing in other existing grant programs. This is because there are a relatively small number of rural teaching hospitals that are training at or over their cap and are eligible to take advantage of the slots provided. The creation of grants under 1820(g) could facilitate the uptake of some positions at rural teaching hospitals, but after the distributions from Section 126 and Section 4122 of the CAA, 2023, there is likely a limited return on this particular investment. Also, it is worth noting that under existing law rural hospitals are already able to receive a cap increase for each new residency program started, unlike urban hospitals that have a "fixed" cap.

Programs like the Health Resources and Services Administration's (HRSA's) Rural Residency Planning and Development (RRPD) grants provide up to $750,000 for new rural residency training programs. One of the biggest obstacles to developing new training programs is the startup costs, because hospitals do not receive any Medicare support for GME programs until residents arrive to train at the facility. This means that hospitals are left to fund the substantial startup costs without any assurance that the program will receive future Medicare support. RRPD grants provide startup capital for new programs to hire faculty, achieve accreditation, and upgrade the hospital infrastructure to accommodate resident trainees. Key to the success of RRPD grants is the ability for grantees to receive technical assistance from rural GME experts who guide hospitals through the difficult first steps of developing new rural residency programs. Since 2019, RRPD grants have led to the development of 46 new rural residency programs training 460 resident physicians. The impact of this program on rural communities across the country cannot be understated. Because of the success of this program, the AAMC strongly supports the Rural Residency Planning and Development Act (H.R. 7855), legislation that would codify the RRPD program.

2. Is codifying remote supervision the best way to provide flexibility to rural hospitals, or are there alternative approaches Congress should consider?

Remote Supervision of Residents
The AAMC strongly supports the remote supervision of residents, and we believe it will allow better access to care and increase training opportunities. We supported this practice during the pandemic and appreciate that CMS finalized a policy to permanently allow teaching physicians to virtually supervise residents in rural areas for both services when the resident and patient are together in person (herein referred to as in-person services) and telehealth services. We also appreciate the extension of virtual supervision of residents for telehealth services in urban areas through December 31, 2025. With the policies in effect, residents have been virtually supervised safely and effectively for both in-person and telehealth services.

We have continued to urge CMS to permanently allow for virtual supervision of residents for both telehealth and certain in-person services in all regions of the country. Our recommendation

for this draft bill is to modify the language included in section (u) by deleting the clause that would allow virtual supervision of residents "**only in clinical instances when the service is furnished virtually.**" The language in this draft legislation is more restrictive than the existing policies that CMS permanently finalized for the virtual supervision of residents in rural areas. Instead, we recommend that virtual supervision of residents by teaching physicians be "allowed for both telehealth services and 'in-person services' that **may be furnished safely and effectively**." This would provide CMS with the flexibility to work with providers to identify services (that are safe and effective) for which this virtual supervision policy would apply.

Other Potential Rural Policies
The primary limitation on rural GME development continues to be the lack of infrastructure necessary to sustain residency training programs. Allowing Indian Health Service or tribal facilities to be non-provider sites for GME purposes would help move towards expanding training opportunities and increasing access to care for these communities. The AAMC is a strong supporter of Rural Track Programs (RTPs), which have increased in development and implementation since Section 127 of the CAA, 2021 removed the separate accreditation requirement and allowed rural hospitals to take advantage of the RTP cap increase without having to start an entirely new training program.

However, each RTP has had to overcome unique challenges, including a lack of infrastructure necessary to meet accreditation requirements and participate in GME training. Specifically, RTPs must have the educational faculty and program staff necessary to meet accreditation requirements, appropriate oversight from attending physicians who oversee resident rotations, and clinical opportunities that align with the learning objectives of a residency program. Missing one of these necessary elements can thwart the development of a new RTP. Despite these challenges, RTPs continue to thrive. However, they are still subject to caps on the number of residents that they can train. Increased cap flexibility in these programs could yield even more rural residency training at established, thriving programs.

Another challenge facing RTPs is that the program requires that greater than 50% of training must take place in a rural setting – a requirement that, for many hospitals, 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 greater than 50% rural training requirement. This legislation 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.

The AAMC believes that the following policy changes could yield increased training in rural areas:
(1) allow a new cap building window for those RTPs with established RTP caps in existence prior to October 1, 2022, which would allow for the expansion of proven rural training programs,
(2) remove RTP residents altogether from a hospital's GME cap; or
(3) either reduce the greater than 50% requirement for RTPs or remove the threshold requirement altogether.

3. Are the proposed data categories in Section 7 sufficient for understanding the GME landscape without overburdening small hospitals? Are there other useful data points or reporting methods that should be included?

The proposed data categories in Section 7 are sufficient for understanding the GME landscape and are all currently reported by teaching hospitals to the federal government or accrediting bodies. Teaching health systems and 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 are encouraged by Section 7's emphasis on using existing sources of data to complete this report. The AAMC supports transparency, and we also remain opposed to duplicative and unnecessary reporting. Though concerns have been raised about overburdening small hospitals, indeed *all* teaching hospitals regardless of size are consistently required to report reams of information, not just in the GME program, but across all federal programs.

We appreciate your interest in protecting residents' privacy and support collecting any resident data at the hospital level as opposed to the program level. There are significant privacy issues with providing data at the program level that could lead to individual residents being publicly exposed for what should be a private issue. We would also highlight that some hospitals have one or two small residency programs which could make resident identification even more likely. While aggregating at the hospital level for institutions with many residents or programs might provide the bare minimum level of privacy for residents, at smaller hospitals, or those hospitals with only a small number of residency programs, it likely would not. Publicly publishing data about attrition data at any level bears a risk of identifying individuals and removing anonymity from the process. Residents are, at their core, in training, and remedial issues must be addressed with discretion to not create unnecessary attention or violate the privacy of the resident.

Congress should also not create policies that operate as disincentives for hospitals to make the difficult decision to remove a resident from a training program. It is presumed that the vast majority of residents will complete their training, and where necessary, programs will decide if a resident is unfit for independent practice. This is necessary to ensure the overall quality of the physician workforce. Nationally, in the 2023-2024 academic year, only 270 residents were dismissed from training programs out of 162,644 residents in training for the year (0.17%). As previously mentioned, this data is collected by the Accrediting Council for Graduate Medical Education (ACGME) and if there are issues with program dismissal rates, it is the duty of the accrediting body to review this information, investigate complaints, develop corrective measures, or facilitate appropriate interventions where necessary. Again, we remain supportive of transparency, but not at the expense of patient care, or residents' privacy.

4. Is creating a GME Policy Council the right approach to guiding future GME slot allocations? Is the scope and responsibility of the Council adequate to make it effective?

The AAMC believes that if there are positions remaining or as part of any future slot allocations, Congress and CMS should refrain from mandating specialty distribution and rather provide flexibility to local communities, teaching hospitals, policymakers, and other regional leaders who

have a better understanding of the complex factors that determine specific provider needs. To that end, we do not believe that the creation of such a council constitutes wise deployment of already limited federal resources, and we have strong concerns with Congress ceding any GME slot distribution authority to a federal advisory committee. We strongly recommend removing this provision. The legislation awards 5,000 FTEs from 2027 through 2031, but input from the GME Policy Council applies to positions awarded after 2032. With the high demand for Medicare-supported GME slots, it is unlikely that many, if any FTEs will be left over for distribution through the recommendations of the GME Policy Council. We urge you to also consider that many teaching hospitals have been excluded from distributions because of CMS' prioritization based on Health Professional Shortage Area (HPSA) score. The number of hospitals that have been eligible for distributions under Section 126 and Section 4122 is a subset of teaching hospitals nationally. Because we expect that CMS will not be able to use the same distribution prioritization policy for slots created under this draft legislation, the number of institutions eligible to receive awards will likely be far greater.

Alternatively, CMS could leverage the Council on Graduate Medical Education (COGME) and other physician training stakeholders to provide input to policymakers. COGME has expertise that has been key in developing programs with high impacts on rural and underserved communities and has been instrumental for the HRSA-administered Teaching Health Center Graduate Medical Education (THCGME) Program and rural residency programs. COGME has also fostered stakeholder communities in rural and underserved areas. These are critical areas of workforce development and COGME and other stakeholders could provide input on the distribution of unawarded positions to both Congress and the Secretary of Health and Human Services (HHS).

5. Are there any categories of high-need hospitals with potentially higher GME costs that are not already captured in the bonus rates for the proposed standardization of PRA for new slots?

The AAMC has conducted a preliminary analysis on the proposed new per resident amount (PRA) bonus structure, which is based on the proposed formula and historical data from the Fiscal Year 2022 Medicare cost reports. We are gravely concerned that, as written, AAMC member teaching hospitals will, on average, see an average PRA for these new slots that is lower than their current PRA. Based on our initial analysis, this policy would create extreme swings between states with some states seeing a new average PRA that is up to $46,000 higher than their current average hospital PRA and other states seeing a new PRA up to $42,000 lower than their current average hospital PRA. Our analysis also suggests that nearly a quarter of rural teaching hospitals would see a decrease in their PRA under this proposal. We also expect there will be dramatic swings amongst individual teaching hospitals within states which would lead to certain teaching hospitals being cannibalized to support others. We are happy to discuss this state-specific data further, as it negatively impacts some of your states and other Senate Finance Committee members. We must also share our concern that the potential financial uncertainty and administrative burden created under the proposed PRA and bonus program proposal could undermine your efforts by disincentivizing those teaching hospitals best positioned to increase training programs from applying for these positions. Should the proposal advance, we urge you

to provide certainty and flexibility by enabling teaching hospitals to choose between their historic or established PRA and the new system for any new awards.

Providing Flexibility in PRA Use for New Slots
As part of the determination for the direct graduate medical education (DGME) reimbursement, a hospital-specific PRA is assessed on direct costs captured in the PRA base year. For most institutions, the PRA base year aligns with the implementation of the inpatient prospective payment system in the early 1980s. Hospitals without a PRA are assigned one based on the lower of either the actual costs incurred in the base year or the average PRA for hospitals in the geographic area. For many hospitals, the PRA does not accurately or adequately reflect the actual training costs incurred by the institution. The calculation for the national weighted average PRA takes into consideration the current PRA and then reduces it by twenty percent.

Because CMS assigns a PRA subject to base year costs, some hospitals have artificially low PRAs, far below the national average. For these institutions, likely, they did not accurately capture the GME training costs in the PRA base year – inadvertently setting a low PRA. For this reason, the AAMC suggests that the legislation provide the new slots on the receiving hospital's choice of either their established PRA or the national average PRA to ensure that Medicare's share of GME training is more appropriately recognized.

Establishing Ranking and Bonuses Based on Workforce Needs
The AAMC recommends that Sec. 2 (b)(G)(v)(II) RANKING be modified to include both primary care and specialty physicians. AAMC data show that there are shortages of *both* primary care and specialty physicians in every state, and MedPAC data show that more Medicare beneficiaries per year have difficulty finding a new specialist (11% of beneficiaries) than finding a new primary care physician (7% of beneficiaries).[1,2] Therefore, solely focusing on primary care stands to disadvantage states and communities that have an adequate supply of primary care physicians and too few specialty physicians. Additionally, statutorily locking in reliance solely on the number of primary care physicians could prove to be short-sighted in an environment where physician assistants and nurse practitioners can contribute more significantly in a team setting.

The AAMC is concerned that ranking and assessing PRA bonuses based on the relative number of primary care physicians in the state would withhold funds to hospitals for factors far outside of their control and inadvertently punish states that have invested in primary care physician retention. There appears to be a negative incentive present in this bonus structure, wherein states with fewer primary care physicians get the bonus, while those with a relatively high number of primary care physicians receive a lower PRA.

Calculating Hospital-Specific Weights
Greater clarification would be helpful in calculating the hospital-specific weight. Specifically,

[1] The Complexities of Physician Supply and Demand: Projections From 2021 to 2036: https://www.aamc.org/media/75236/download?attachment
[2] MedPAC March 2024 Report to Congress: https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC-3.pdf

the calculation for hospital-specific weights found under 1886(h)(2)(G)(iii)(III)(aa) does not differentiate between primary care or specialty PRAs. Between the years 1993 and 1995, Congress temporarily froze the inflationary PRA increase for specialty programs. Because of this, most hospitals training residents during those years have two PRAs; a specialty PRA and a primary care PRA. The legislation does not specify which PRA should be used to assess the hospital-specific weights.

Ensuring Consistent Determinations for PRAs by Year of Award
As mentioned above, a PRA is assessed in a base year. Once established, the PRA is only updated by an annual inflation adjustment. Each hospital awarded positions under this legislation would have to track the assessed PRA and the number of residents eligible for the PRA base year calculation, along with the hospital's primary care and non-primary care PRAs. Practically this means that receiving an award from one round of distributions would require a hospital to calculate, at minimum, two and likely three, different PRAs. If a hospital receives awards in multiple rounds of distributions, they could have different PRAs for each year they are awarded new FTEs.

The year-to-year fluctuations in PRA change due to the bonus structure would be dependent on variables beyond the control of a single teaching hospital including the number of primary care physicians changing within the state, the hospital losing Medically Underserved Area (MUA) status, and the dual eligible patient mix changing relative to other hospitals nationally. While we appreciate why the legislation seeks to provide greater reimbursement for hospitals in disaster areas, the five-year lookback may not be the best method. We suggest you amend the language to consider disaster size and acuity, but we would highlight that it is common for hospitals outside of disaster areas to treat patients from the disaster area. A possible consideration for disaster area qualification could be hospitals in states that have received, cumulatively, more than $1 billion in disaster relief in the preceding 36 months.

The swing between PRAs could be drastic, for instance, a small rural hospital that is not a tier 1 or 2 trauma center and no longer meets the "Disaster Designation" requirements could see the "high expense" bonus go from 45% to 0. This is unnecessarily complicated for institutions, and while there might be a policy argument for allowing institutions to receive a national average PRA (not adjusted by 0.8) when that is the choice of the institution, the national average PRA should be consistent from year to year.

Clarifying Application of New PRA Rates
The AAMC would also highlight that an interpretation of the legislation could mean ***any*** newly created GME FTEs receive the national PRA base rate. This is a significant issue for the future development of GME training at non-teaching hospitals. Any hospital that has not had resident rotators is eligible to establish a PRA and build a Medicare GME FTE cap. Because GME training costs can vary tremendously by geographic region, limiting hospitals to an average PRA could be prohibitive for GME development.

We are concerned that the potential financial uncertainty and administrative burden created under the proposed PRA and bonus program proposal could undermine your efforts by

disincentivizing teaching hospitals from applying for these positions. Should the proposal advance, we again urge you to provide certainty and flexibility by enabling teaching hospitals to choose between their established PRA and the new system for any new awards.

Additional Feedback on the Draft Legislation

The AAMC appreciates your specific questions on the legislation and would like to provide additional feedback on other areas of the bill.

Priority for distributions to hospitals that serve rural and underserved areas, and hospitals that are affiliated with certain medical schools.
The AAMC asks that you consider changes to the prioritization categories described in (11)(B)(iv). We are concerned that the current language in paragraph (iv) "shall consider" could be too restrictive without further direction to CMS. We request that you stipulate that 1,000 FTEs per year are available for each round of distributions, and add a fourth category, directing CMS to consider prioritization criteria based on qualifying hospital characteristics in paragraph (ii).

Requirement that hospitals be located in Medically Underserved Areas (MUAs) as a prioritization criterion.
After three rounds of distribution under Section 126 of the CAA, 2021 based on the CMS-created distribution prioritization which gives priority to HPSAs, there are specific lessons learned. Most residency training takes place in areas that do not meet the requirements for being rural or MUA because programs need a minimum number of physicians to oversee and facilitate resident training. Because of this, we do not feel that MUAs are a good prioritization criterion for slot distributions.

In response to the Section 126 requirement that at least 50% of training take place in a HPSA, the AAMC and other stakeholders requested that CMS consider the patient population rather than the geographic location of where training takes place. We believe this Congress intended to give priority to institutions that *serve* populations that live in a MUA, and the AAMC strongly believes that a demonstration of serving MUAs would be a better measure than being *located* in a MUA. An example of the shortcomings of geographic training location requirements has to do with the Section 126 distribution prioritization based on HPSA scores. The boundary for one HPSA runs along a major highway in Texas, where the regional hospital happens to be on the other side of the HPSA demarcation. The hospital serves the HPSA population, because of proximity, but because of CMS's prioritization program for Section 126 distributions, the hospital has effectively been locked out of the ability to receive new slots. This is also true for hospitals that serve rural patient populations. Where there are few clinical options, patients will travel to the closest hospital, which is very likely not in a rural area.

Clarifying institutional affiliation language
Under subparagraph (III) the language states "affiliated with an eligible institution described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a) that establishes a college of medicine." The AAMC believes that this section intends to give priority to hospitals

that *have* or establish affiliations with institutions so described in the Higher Education Act, and those that establish affiliations with those institutions that create a college of medicine in the future. Clarifying language might be useful in stating "affiliated with an eligible institution described in section 371(a) of the Higher Education Act of 1965 (20 U.S.C. 1067q(a)) ~~that establishes a college of medicine~~."

Expanding relief to hospitals with artificially low caps
Section 131 of the CAA, 2021 allowed certain hospitals with low FTE counts to receive an adjustment to the Medicare FTE cap when it trained residents in a new residency program. The section 131 requirements are narrow and the short duration of five years to meet this requirement has proven to be difficult for some institutions. While removing the five-year window for Section 131 resets is a good first step, Congress could look to more expansive policies to increase residency training at institutions with artificially low FTE caps. A policy that we suggested in our letter to the bipartisan Senate GME working group last year was to allow any institution that can demonstrate that it has not had resident rotators in the last 10 years to reset its FTE caps.

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

Sincerely,

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Chief Public Policy Officer
Association of American Medical Colleges

CC: David J. Skorton, MD
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