AMERICA'S ESSENTIAL HOSPITALS

June 25, 2024

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

The Honorable Robert Menendez
United States Senate
528 Hart Senate Office Building
Washington, DC 20510

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

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

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

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

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

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

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

America's Essential Hospitals commends your efforts to improve Medicare physician training to mitigate the ongoing health care workforce crisis. Essential hospitals play a key role in training and supporting the provider pipeline and ensuring the next generation of clinicians and allied health professionals is equipped to meet the health and socioeconomic needs of the communities they serve. We want to work with Congress to advance policies that will enable essential hospitals to continue caring for Americans with the greatest health and socioeconomic needs by sustaining and strengthening the health care workforce.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to equitable, high-quality care for all, including those who face social and financial barriers to care. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health, health care access, and equity. We support our 300 members with advocacy, policy development, research, education, and leadership development. Our members provide a disproportionate share of the nation's uncompensated care, and three-quarters of their patients are without medical insurance or covered by Medicare or Medicaid. Essential hospitals provide

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state-of-the-art, patient-centered care while operating on margins less than one quarter that of other hospitals.[1]

Essential hospitals are at the forefront of training the next generation of physicians and are ready to work with the committee to help mitigate our country's workforce challenges. In 2021, member teaching hospitals trained more than three times as many physicians as other teaching hospitals (246 physicians per essential hospital compared with 81 physicians per other hospital on average).[2]

Because essential hospitals are committed to high-quality care for all, including those who face social, financial, and geographic barriers to care, **residents at essential hospitals are trained to meet the needs of underserved populations, including their needs for mental health and primary care to help manage chronic conditions**. Although many physicians are reluctant to serve Medicaid patients and patients without medical insurance, those trained at essential hospitals are prepared to help fill this health equity gap.

Essential hospitals also play an important role in training physicians to serve in rural communities. Although the main campuses of many essential hospitals are in urban areas, many of our members operate clinics in rural areas or partner with rural hospitals to provide graduate medical education (GME), giving residents opportunities to train in these communities. **We urge the committee to explore ways that essential hospitals can continue to partner with rural communities to help advance our shared workforce goals.**

Below, we offer specific comments on the questions that the committee raised about its draft legislation. We hope that we can continue to be a resource to the committee as it seeks to allocate additional GME funding fairly and equitably.

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

The greatest barrier that essential hospitals face in expanding their residency programs is the artificial limit that Congress placed on Medicare GME funding in 1996. We agree with the committee's assessment that these caps do not reflect current needs, and we support efforts to raise these caps to help meet the needs of underserved communities.

Despite the lack of adequate funding, many essential hospitals train more residents than their Medicare GME cap to meet the needs of their communities. According to our analysis of 2022 Medicare cost reports, essential hospitals trained 36 percent more residents than their Medicare GME caps. In total, nearly 10,000 resident positions at our member hospitals were unfunded in 2022. These unreimbursed costs add to the many financial challenges that essential hospitals face because of their commitment to providing equitable, high-quality care for all. Even if Congress adds new GME slots, costs associated with existing training will remain, making it exceedingly difficult for essential hospitals operating on shoestring budgets to further expand training, even where need is significant, without dedicated sources of new GME funding.

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[1] Taylor J, Ramiah K, Greig M, et al. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2021 Annual Member Characteristics Survey*. America's Essential Hospitals. October 2023. https://essentialhospitals.org/wp-content/uploads/2023/10/2023-Essential-Data_single-pages.pdf. Accessed May 8, 2024.
[2] Ibid.

SUPPORTING UNDERSERVED COMMUNITIES

As Congress decides where to prioritize the placement of additional residency slots, we urge the committee to target new slots to underserved non-rural areas in addition to rural areas. To achieve this, the committee should consider hospital payer mix and target additional residency slots to essential health systems, as defined in the bipartisan Reinforcing Essential Health Systems for Communities Act (H.R. 7397). This bill identifies a subset of hospitals in both urban and rural areas that serve a high share of Medicaid, Medicare, and uninsured patients, which is consistent with the definition of a safety net provider the Institute of Medicine proposed more than two decades ago.[3] While we agree that increasing training in rural areas is important, it is equally important to mitigate the physician shortage that plagues underserved non-rural communities. A sole focus on increasing training in rural areas will still leave harmful gaps in care for some of our nation's most underserved populations.

Prioritizing the training of residents in facilities that serve a high share of patients living on low incomes is important to ensure that physicians are trained to meet the health needs of underserved populations. For example, trainees at essential hospitals are better prepared when they graduate to care for people and communities facing barriers, including those with chronic conditions and complex health and social needs. And by training at facilities that serve more Medicaid patients and individuals from underserved communities, graduates from essential hospitals may be more likely to accept new Medicaid patients and help reduce disparities in access among Medicaid, Medicare, and private insurance.[4]

Unfortunately, essential hospitals have not received priority in prior cap distributions. Unlike rural hospitals, which have an opportunity under current law to obtain new GME slots any time they establish new programs, essential hospitals are limited to obtaining new slots only through congressional authority. As a result, new programs at essential hospitals are often completely unfunded by Medicare and operate at a financial loss to the hospital. Adding a new priority category for essential hospitals to the allocation formula would further Congress' purpose of improving physician retention in underserved communities.

IMPROVING DISTRIBUTION OF GME SLOTS

As the committee considers other ways to improve the distribution of slots, we encourage Congress to increase the minimum number of slots available to applicant hospitals from prior distributions to ensure that new funding supports the development of new and meaningfully expanded programs. The proposal of 10 additional slots per hospital is an improvement from recent allocations, but Congress should consider a larger limit for essential hospitals to encourage expansion of residency programs in settings that are more likely to improve care for the underserved. In addition, Congress should allow hospitals the opportunity to apply for all new slots at one time rather than set annual caps and require hospitals to reapply each year to reach their maximum number of slots. Given the significant time and resources needed to

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[3] Institute of Medicine; Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net: Intact but Endangered*. Washington, D.C.: The National Academies Press; 2000. https://nap.nationalacademies.org/catalog/9612/americas-health-care-safety-net-intact-but-endangered. Accessed May 15, 2024.

[4] Medicaid and CHIP Payment and Access Commission. Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey. June 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf. Accessed June 14, 2024.

implement new programs, it is difficult for hospitals to commit to establishing new programs without a complete understanding in advance of the number of slots that will be funded.

PRESERVING RURAL SLOTS FOR RECLASSIFIED HOSPITALS

Congress should, as in past slot allocations, continue to treat reclassified hospitals as rural for purposes of qualifying for new slots. Reclassification has been an important pathway for many essential hospitals to fund training above their 1996 caps, particularly in the absence of other policies directing slots to hospitals disproportionately caring for under-resourced patients. Congress should avoid establishing a novel exception in the treatment of reclassified hospitals as new slots are allocated. Ignoring reclassified hospitals' rural classification could chill the expansion of training in essential hospitals, which as outlined above is critical for preparing physicians to care for underserved patients.

Section 3. Encouraging Hospitals to Train Physicians in Rural Areas

Prioritizing new slots for essential hospitals also will improve retention of physicians in rural areas. Many essential hospitals, especially those affiliated with state teaching universities, currently partner with rural communities to establish or support resident training programs. For example, the Medical University of South Carolina (MUSC), in Charleston, South Carolina, recently received a $4 million private grant to implement a variety of rural health initiatives, including workforce training and the development of a telehealth network for rural primary care clinics.[5] MUSC also has established a GME Regional Network to expand residency training programs in rural and underserved communities across South Carolina. The network combines the resources and expertise of a large academic health system with training in a small community and individualized environment to increase the number of students who serve in rural communities upon graduation.[6] Even though MUSC's flagship hospital is technically located in an urban area (Charleston), this essential hospital is a critical partner for improving access to rural health care.

To sustain these and similar investments, Congress should provide additional funding for essential hospitals to partner with rural communities. For example, funding could help essential hospitals assist rural providers with assessing the feasibility of training programs and obtaining accreditation, providing training and resources to support faculty and student recruitment, offering administrative support services necessary to implement training programs, and sharing GME-related information technology and software, among other initiatives. This additional funding could be provided through modifications to GME payment formulas for these hospitals or a new dedicated funding stream, such as incentive payments to support infrastructure and other investments in rural training.

We also support efforts to extend teaching physicians' ability to use telehealth to supervise resident physicians. Telehealth is an important tool that essential hospitals often use to help support access to care in rural communities. For example, Project ECHO, developed

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[5] Medical University of South Carolina. MUSC receives nearly $4.3 million to implement rural health initiatives. December 12, 2023. https://web.musc.edu/about/leadership/institutional-offices/communications/pamr/news-releases/2023/musc-receives-more-than-four-million-dollars-to-implement-rural-health-initiatives. Accessed June 14, 2024

[6] *Graduate Medical Education in the MUSC Regional Network*. https://muschealth.org/health-professionals/gme-regional-network. Accessed June 23, 2024.

See also: Medical University of South Carolina. MUSC launches program to bring medical residents to areas where they're badly needed. September 14, 2023. https://web.musc.edu/about/news-center/2023/09/14/musc-launches-program-to-bring-medical-residents-to-areas-where-theyre-badly-needed. Accessed June 23, 2024.

by the University of New Mexico, has been a national model for this type of partnership between essential hospitals and rural communities.

Section 7. Data Collection and Transparency

We appreciate the committee's stated desire to improve GME data collection and transparency in a manner that minimizes administrative and reporting burdens and relies on existing data collected for other purposes. We encourage the committee to engage directly with teaching hospitals and associations like America's Essential Hospitals in further developing any new hospital reporting requirements to ensure those goals are achieved. In collecting data, we also encourage the committee to focus primarily on outcomes associated with increased GME funding, such as identifying reductions in the national or local physician shortages, where and in what specialties residents practice following their training, and the number and types of new and expanded programs approved by accrediting bodies. These types of metrics are more likely to assist Congress in assessing whether new legislation is meeting its intended goals.

America's Essential Hospitals commends the Bipartisan Medicare GME Working Group for its interest in advancing additional Medicare GME proposals to address health care workforce shortage and gaps. Congress should continue to pursue opportunities to strengthen the physician pipeline, ensuring future practitioners are trained and equipped to provide high-quality, unbiased care to all. We appreciate the opportunity to offer feedback on the draft policy proposal and look forward to working with lawmakers to support and enhance the health care workforce.

Sincerely,

Bruce Siegel, MD, MPH
President and CEO