Kansas Hospital Association

June 24, 2024

Bipartisan Medicare GME Working Group
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: GME Draft Proposal Outline and Questions for Consideration

Dear Chairman Wyden and Senate Finance Committee Members:

On behalf of our 121 member hospitals, the Kansas Hospital Association (KHA) is pleased to offer comments and feedback regarding the Bipartisan Medicare GME Working Group's Draft Proposal Outline and Questions for Consideration.

KHA is a non-profit membership organization. Our membership includes 82 Critical Access Hospitals, 3 Rural Emergency Hospitals, 19 Rural Sole Community and Medicare-dependent hospitals, and 18 urban hospitals.

KHA believes it is crucial to strengthen Medicare Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) funding to educate, train, and equip the physician workforce in Kansas and beyond to ensure our communities have access to care for years to come. KHA appreciates the Working Group's recognition that changes are necessary to address the significant physician shortages that exist now and that will continue to persist for years to come. We share the commitment towards action to overcome this challenge to educate and train a greater number of physicians, focusing on ensuring physicians enter the workforce in areas that truly need providers.

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

KHA supports the provision to add additional Medicare GME slots from fiscal year (FY) 2027 through FY 2031. We encourage bold investments in GME over multiple years to enhance the number of physicians trained in key shortage areas of the country, including in Kansas. We believe that a core mechanism to achieving this goal is through increasing funds for Medicare GME to create more residency slots and thus producing more highly skilled physicians across Kansas and the country.

In order to properly equip the US health care system to transform into one that prioritizes prevention, a vast increase in the number of primary care residencies is necessary. We believe a minimum requirement of 25 percent of new Medicare GME slots must go towards primary care residencies is appropriate.

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An emphasis on training physicians in programs based in rural and underserved areas is critical if the goal to get more physicians working in those areas is ever to be met. GME programs in rural hospitals can significantly increase physicians' likelihood of staying and practicing in underserved areas after training. Research indicates that between 40 percent and 45 percent of graduates of Rural Training Programs (RTP) enter rural practice compared to only 4.8 percent of graduates across GME.[1] The lack of prioritization for residency slots in rural and underserved areas in the past has risked making underserved areas more underserved. KHA appreciates the Working Group's efforts to reevaluate how rural areas may be eligible to receive GME slots.

KHA encourages Congress review how Health Professional Shortage Areas (HPSAs) are calculated and thus used to influence the apportionment of new residency slots. 28.5 percent of Kansas counties are not considered HPSAs but are rural counties and many face challenges with access to care. We believe this is an important issue that should be corrected for HPSAs to better qualify what areas face primary care shortages.

We believe the current HPSA formula that calculates scores is flawed and does not appropriately account for provider need in communities, particularly in rural areas. The existing components that factor into a HPSA score do not reflect rurality or unique access problems that many rural areas of Kansas face. Additionally, HPSA scores reflect population health measures such as low birthweight and infant mortality rates. While these are important metrics to consider, rural areas in Kansas have a much higher proportion of older adults than to newborns and infants. The older adult populations of rural Kansas result in higher utilization of health services, and their respective risk factors are not accounted for in the existing HPSA formula. Unless the HPSA methodology is updated to reflect these concerns, we do not believe that basing distribution of the additional residency slots on the HPSA score will provide GME funding to go to areas that could most use the additional resources from Medicare GME.

- *How many additional Medicare GME slots are needed to address the projected shortage of physicians?*

According to the 2024 Kansas Health Care Workforce Report[2], Kansas hospitals are short by 200 physicians. This report does not include many other health care practice settings, which would imply a much higher shortage. While broad investments in GME are essential across the country, we believe it is important to focus on increasing residency slots and ensuring physicians are trained in areas that they will be likely to work in following their education and training.

[1] Russell DJ, Wilkinson E, Peterson S, Chen C, Bazemore A. Family Medicine Residencies: How Rural Training Exposure in GME Is Associated With Subsequent Rural Practice. J Grad Med Educ. 2022 Aug;14(4):441-450. doi: 10.4300/JGME-D-21-01143.1. PMID: 35991106; PMCID: PMC9380633).

[2] https://www.kha-net.org/DataProductsandServices/DataPublic/d165169.aspx?type=view

- *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?*

KHA believes that 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 would improve the distribution of physician training and recruitment in rural and underserved areas. While much of Kansas may not be applicable to some of the mentioned criteria, we believe that that has potential to impact other underserved areas across the country and should be added as criteria.

KHA reiterates the need to reevaluate the HPSA calculation to truly reflect rural needs. Congress could encourage the updating of the HPSA formula to reflect these concerns which will improve the number of facilities that are recognized as truly rural and underserved to have greater chances of being awarded new GME slots and also to increase the number of rural facilities that would be eligible to participate in various loan repayment or loan forgiveness programs that often require employment in a facility that is in a HPSA.

Kansas has programs in place that can be utilized to incentivize physicians to work in rural communities that Congress could look to provide assistance towards or incentivize in more states. The State of Kansas established the Kansas Medical Student Loan program to encourage students attending the state's academic medical center practice primary care medicine in areas of need in the State of Kansas.[3] Another program, the Kansas Rural Opportunity Zone Program, is not limited to health care professionals, but is a core recruitment strategy for employers in 95 of Kansas' 105 counties that can provide physicians with student loan repayment assistance or a 100% state income tax credit.[4] Congress could consider avenues to enhance these state programs through federal funding.

Congress could also provide additional stipends for residents who spend a significant portion of their training in rural hospitals or facilities. Housing in many rural areas is increasingly hard to come by, making it more expensive for residents to work and live there. Congress should work to minimize or eliminate these barriers to create clear pathways for rural training and working in rural and underserved communities.

- *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?*

According to the ACGME list of Graduate Medical Education Totals by State for the 2023-2024 Academic Year, Kansas ranks 34th by number of residents.[5] While the proposal outline does not explain what the cutoff would be for states with the lowest number of GME slots, KHA believes increasing caps for low GME slot states is helpful. However, another factor we encourage the Committee to consider is that some states

[3] https://www.kumc.edu/documents/sfa/KMSL-%20Primary%20Care%20Information%20Sheet.pdf

[4] https://www.kansascommerce.gov/program/taxes-and-financing/rural-opportunity-zones-roz/

[5] https://apps.acgme-i.org/ads/Public/Reports/Report/13

like Kansas have a small number of sponsoring institutions primarily due to the reality that smaller populations states have fewer medical colleges. Despite Kansas historically having just one medical college, with one more recently opening, the state has done well in training sizeable numbers of residents based on this ratio. We encourage the ratio of medical colleges in a state to be factored in when evaluating increasing the cap for hospitals in states with low numbers of GME slots. States like Kansas, while not in the lowest 10 states by GME slots, could be well equipped to be granted more GME slots and truly translate those slots into producing more physicians in areas of need.

SECTION 3. Encouraging Hospitals to Train Physicians in Rural Areas

Kansas has multiple Sole Community Hospitals (SCHs) that have expressed interest in creating new residency programs. A barrier to this has been the inability of those hospitals to receive IME payments. These programs would be rural-based and have access to a variety of practice sites due to ample numbers of regional Critical Access Hospitals. Thus, they could offer high quality training experiences to new physicians. KHA strongly supports the provision to allow SCHs and Medicare-dependent hospitals (MDHs) to receive IME payments to support the cost of training residents in rural communities.

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

Kansas has 101 rural hospitals. 82% of hospitals have losses on services and 56% of hospitals are at risk of closing.[6] States like Kansas could be greater leaders in the rural training of physicians; however, inadequate reimbursement and other financial challenges prohibit most hospitals from even considering their ability to launch new residency programs. Data from 2020 indicates that Medicare margins in Kansas are negative by 5.3 percent. Sequestration has remained a concern among hospitals that inflates these negative margins, but even if sequestration were eliminated, Medicare would still fail to cover the cost of care.

KHA strongly urges Congress and CMS to eliminate cuts to protect Kansas' health care safety net and implement reimbursement policies that reflect current market forces. **Congress should make the Medicare-Dependent Hospital Program permanent and make the Low-Volume Hospital higher threshold permanent.** Congress should additionally take action to protect the 340B program which is a lifeline for many rural hospitals. Once sustainability issues like this are addressed, it is important to evaluate funding to support rural hospitals' start-up costs for new residency programs. That is imperative to have support for if a rural hospital wanted to seriously consider creating a new program.

Other barriers for hospitals in rural and underserved areas are numerous. While some rural hospitals have strong volumes that could sustain a robust residency program, the reality is that many rural hospitals on their own lack sufficient patient volumes to build competency for residents. Additionally, rural areas would have more difficulty recruiting faculty to staff the program. The need for core faculty that can cover all the

[6] https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

ACGME requirements is imperative but can be very hard to find in rural areas, particularly when recruiting the subspecialty faculty that many residency programs require.

Our workforce in Kansas also has struggles to obtain housing. Housing options in rural areas can be very limited and/or expensive. This is a significant barrier for those who may only stay in that single location for three years, and it's an even bigger barrier for those in Rural Training Tracks that will be in a new rural location for only two years.

- *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?*

The Working Group's proposal to include SCH and MDH hospitals to receive the "regular" DGME and IME payments is essential to improve the feasibility of rural hospitals to open new residency programs. In addition to this, **the IME payment formula should be adjusted to provide higher reimbursement rates for rural hospitals.** This can be done by increasing the weighting factor for rural hospitals to reflect the higher costs and additional challenges associated with training residents in these settings. **A rural hospital bonus payment should also be introduced for hospitals establishing and maintaining residency training programs**. This bonus can incentivize rural hospitals to invest in training programs.

- *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 Medicare Rural Hospital Flexibility Program (FLEX Program) is an existing program that the Committee could expand to include technical assistance for Critical Access Hospitals to apply for Medicare GME slots. Another program that could be leveraged is the Small Rural Hospital Improvement Program (SHIP). SHIP grants could incorporate GME slot application support to help cover costs associated with the GME application process. The Committee could also increase funding and expand the mandates of State Offices of Rural Health so that the offices can provide support for rural hospitals in applying for GME funding.

- *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?*

A clear incentive to encourage this type of partnership is to provide higher reimbursement rates for residency programs that include rotations or training periods in rural hospitals or clinics. This funding would greatly facilitate new urban-rural collaborations to advance the common goal of training more qualified physicians for our communities. A new grant program could also be created that would be offered to hospitals that partner with rural facilities. Many hospitals, particularly urban hospitals, are over their GME cap. Another incentive that can be considered is to increase the existing cap for hospitals that invest in new primary care/rural/community-based residencies.

If the federal government would provide funding to states in addition to hospitals through GME, that could also strategically increase the number of residencies, particularly for high-demand specialties that communities and the state needs. This is an important component in evaluating GME funding reform overall to ensure progress is efficiently made in advancing these goals.

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

To strengthen and expand existing rural track programs, Congress can increase funding for these programs within the Medicare GME budget. The per-resident amount should be increased to reflect the costs associated with training in rural settings better. Rural GME grants should be considered which could enable programs to cover costs associated with faculty recruitment, infrastructure, and resident stipends. Additionally, loan repayment and loan forgiveness programs for residents who commit to rural track programs should be expanded to encourage more physicians to enter these tracks. The flexibility of caps also needs to be considered. Rural track programs could be allowed more flexibility in their residency slot caps so they can expand without facing prohibitive limits.

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

KHA agrees with the Working Group and supports the proposal that would provide ten years rather than five years for eligible hospitals to establish a new per resident amount (PRA) or residency full-time equivalent (FTE) cap. If the Committee is considering whether additional hospitals should be eligible to reset their low GME caps, we believe appropriate eligibility criteria could include that the hospital will collaborate with rural hospital(s).

SECTION 6. Improvements to the Distribution of Resident Slots Under the Medicare Program after a Hospital Closes

KHA agrees that revising the current law on how CMS must redistribute a hospital's residency positions if the hospital's program closes is important. Congress should consider the creation of a closed program "bank" that would absorb GME slots when programs close so that the bank can redistribute them into shortage areas. We believe it is important for spots from shortage areas to remain in shortage areas when redistributed, and a "bank" structure could help achieve this.

Other Considerations:

In the 2025 IPPS Proposed Rule, CMS made several requests for information on the topic of GME. KHA has concerns that CMS may be evaluating future rulemaking that may make it harder to open new residency programs. KHA and other health care organizations expressed comments to CMS, and we reiterate them for this Committee to consider preemptive steps to prevent unnecessary restrictions by CMS on residency programs through potential future regulatory action.

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CMS expressed interest in the topic of commingling in residency programs. We believe that commingling of residents is appropriate in an existing residency program and for new residency programs. Commingling may occur for many reasons such as the ability to share didactic experiences, fulfilling specialty experiences that many residents need to take part in that might have limited specialists available, or to service needs such as requiring a certain number of residents to staff an inpatient service and getting those numbers from two different programs.

In a Rural Training Track, Kansas programs have more commingling because of the nature of the program. In this setting, it is helpful for the smaller program with smaller faculty to have the opportunity to present during didactics, but not have to recreate the wheel with more limited resources. The commingling also increases idea sharing and differing perspectives which builds greater discussion amongst residents.

KHA believes it important to take this time to reiterate that ACGME supports programs sharing faculty, especially for sub-specialties that can be very difficult to find. Aside from potential new restrictions on the commingling of residents, **KHA urges CMS not to place restrictions on faculty members being commingled and encourages the Committee to prevent restrictions from being implemented by CMS.** With residents from multiple types of programs needing to rotate through specific specialties, in some areas, including urban areas, residents may need to rotate through a specific specialty physician. KHA believes that is entirely appropriate as long as programs have sufficient patient volumes to take on additional residents.

Additionally, the **Committee should protect against any potential future proposals that would place restrictive thresholds for the relative proportions of experienced and new teaching staff and program directors in new residency programs.**

New residency programs should desire to have staff with as much experience as possible, particularly because the program is a new program. Requiring a new program to have a certain percentage of faculty who have not been teaching in other programs seems to be educationally backward. Some programs may be forced to start with brand-new faculty due to circumstances outside of their control, such as challenges starting from scratch at the baseline or if the residency program is in a more isolated area. This should be an exception to the goal rather than the mandated requirement to have all or a significant proportion of brand-new teaching staff. Physicians are not trained how to be an educator. Developing an education skillset takes time, and it can be crucially helpful when a new faculty member is surrounded by experienced faculty in a residency program.

KHA recommends to CMS and reiterates to the Committee against setting specific numerical thresholds for the relative proportions of experienced and new teaching staff both for urban and rural residency programs. Strict limits should be avoided since small or rural programs may have additional struggles to comply with due to limited resources or a smaller pool of potential faculty and staff available. KHA encourages CMS and the Committee to continue to ensure new residency programs meet ACGME standards but limit any new requirements that may impede a new residency program from opening. The physician shortage in the United States is a challenge that will not be met by making it harder to train new residents via new residency programs.

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At the bottom line, we do not believe "newness" should be defined by the absence of teaching and leadership experience within a specific timeframe. It is important for a new program to have faculty and a program director have experience so they know how to navigate the challenges of recruitment, evaluation, curriculum design, and dealing with struggling learners, among other points. KHA has concerns about any future proposed rule from CMS that would emphasize faculty needing to be new or "rusty" to be considered for funding. That kind of program would not likely have the experience in education necessary to make it successful in the long run.

KHA believes that if CMS were to impose increased restrictions on program directors, it would deprive new residency programs of the benefit of experienced program directors. New residency programs are essential to supply the demand of our communities. If we want new programs to be equipped for success and flourish into programs that provide excellent training, we should want the new programs to be filled with experienced educators.

Nearly 70% of Kansas' counties are considered Primary Care Health Professionals Shortage Areas.[7] Kansas hospitals and health care organizations are short by hundreds of physicians. It is our view that new restrictions will only prevent the opening of new residency programs, which does not advance the goal of providing more qualified physicians to supply the demands of our communities. We desire to work collaboratively with CMS, the Senate Finance Committee, and other partners to identify new ways to support and maintain our existing and new residency programs while removing unnecessary barriers to training more physicians in the United States.

Thank you for the opportunity to offer comments on this draft proposal outline and for considering our feedback. We believe there are many opportunities to improve the physician workforce and thereby increase access to and quality of care in communities across the country.

If you want additional information, please contact Shannan Flach at sflach@kha-net.org or Jaron Caffrey at jcaffrey@kha-net.org.

Sincerely,

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[7] Kansas Hospital Association, *2024 Kansas Health Care Workforce Report, (*April 2024). https://www.kha-net.org/DataProductsandServices/DataPublic/d165169.aspx?type=view

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