



June 24, 2024

The Honorable Ron Wyden
U.S. Senate
221 Dirksen Office Building
Washington, DC 20510

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

The Honorable Bob Menendez
U.S. Senate
528 Hart Office Building
Washington, DC 20510

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

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

The Honorable Thom Tillis
U.S. Senate
113 Dirksen Senate Office Building
Washington, DC 20510

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

The Honorable Marsha Blackburn
U.S. Senate
357 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Wyden, Cornyn, Menendez, Cassidy, Bennet, Tillis, Cortez Masto, and Blackburn:

On behalf of the more than 90,000 members of the American College of Surgeons (ACS), I appreciate the opportunity to respond to your draft proposal on the Medicare graduate medical education (GME) program. The ACS was founded more than a century ago as an organization focused on quality. Ensuring that surgeons receive the highest quality of training can lead to fewer complications and better outcomes, thus lowering the cost of care. The ACS has long supported legislative efforts to increase the number of GME positions available in underserved areas and thanks Congress for its efforts to meet the nation's health care workforce needs. However, we also assert that increasing the number of positions alone is not enough. We must ensure that the right type of physician is at the right place, at the right time, to optimally meet the needs of a particular population.

As we discuss below, the ACS strongly believes that obtaining accurate and actionable workforce data is a critical prerequisite to any GME reform efforts. In addition, we propose that a single stream of funds for both indirect medical education (IME) and direct graduate medical education (DGME), managed by a regional governance body accountable for receipt of those funds, could remedy much of the complexity inherent in the current system. Finally, while continued

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investment in primary care and psychiatry is needed, it is essential that policymakers consider the full range of medical and surgical specialties when addressing health care workforce challenges.

The ACS appreciates the Senate Finance Committee’s attention to this critical issue and welcomes the opportunity to share our response to a few of the questions offered for consideration.

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?

The ACS thanks Congress for its critical investment in the physician workforce by adding 1,200 new Medicare GME slots in the *Consolidated Appropriations Act, 2021* and the *Consolidated Appropriations Act, 2023*. This was an important recognition of the growing problem of patient access to care, particularly in rural areas of the country. The ACS has long supported the *Resident Physician Shortage Reduction Act* (S. 1302/H.R. 2389) that would raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new slots.

However, we also assert that increasing the overall number of federally funded positions is an imprecise solution to the health care workforce problem. For many physician specialties, the problem is distribution rather than total supply. For example, a 2020 report conducted by the Health Resources and Services Administration (HRSA) found that there is a serious maldistribution of general surgeons in the US, with supply only able to meet approximately 69 percent of demand in rural areas and 75 percent of demand in suburban areas.¹ The task for policymakers is to understand where access issues are and take steps to incentivize practice in those areas. The most recent Association of American Medical Colleges (AAMC) workforce assessment indicates the future demand for physicians needed to provide the national average level of care and ensure equal access will be greatest not in primary care, but in the medical and surgical specialties in both urban and rural areas, predominantly in the South and West census regions². Thus, while continued investment in primary care and psychiatry is needed, it is essential that policymakers consider the full range of medical and surgical specialties when addressing health care workforce challenges.

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 ACS shares the goal of supporting residency training in rural areas. Increasing the number of GME slots at rural institutions is one way to achieve this, but supporting clinical rotations at rural facilities is another. As full training in many needed surgical specialties may exceed the opportunities of rural training sites alone, Congress may consider directing additional slots to

¹ Health Resources and Services Administration Report to the Senate Committee on Appropriations, 2020, <https://www.facs.org/media/agaj2m1r/hrsa-general-surgeon-projection-report-to-appropriations.pdf>

² The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. March 2024, accessed June 21, 2024. <https://www.aamc.org/data-reports/workforce/report/physician-workforce-projections>

training programs that include at least 12-month rotations in rural areas to help expose more resident physicians to rural practice. Though Congress should support residency programs at rural facilities, certain existing training programs at non-rural institutions are well positioned to apply for and support additional GME slots, while still offering significant exposure to rural practice environments.

How could Congress improve the recruitment of physicians to work in rural or underserved communities?

As mentioned above, simply increasing the number of GME slots is not sufficient to ensure nationwide patient access to the appropriate type of care in a timely fashion. This will also require the appropriate distribution of physicians to meet identified workforce needs and therefore incentives for physicians to practice in underserved areas.

The high cost of medical education is one barrier to individuals wishing to practice in underserved areas. As you are aware, physicians often accumulate immense student debt during their education, and then must undertake several years of residency training with relatively low pay, during which time their student loans accrue significant interest. The ACS supports legislative efforts to reduce the burden of student loan debt on physicians, including the *Resident Education Deferred Interest Act* (S. 704/H.R. 1202), which would allow borrowers in medical or dental internships or residency programs to defer student loan payments without interest until the completion of their programs, and the *Specialty Physicians Advancing Rural Care Act* (S. 705/H.R. 2761), which would establish a new loan repayment program for specialty physicians practicing in rural areas.

In addition, the ACS supports reauthorizing the Health Professional Shortage Area (HPSA) Surgical Incentive Payment Program (HSIP) for a period of five years. The HSIP, which expired in 2015, provided a payment incentive to surgeons who performed major operations—defined as those with a 10-day or 90-day global period under the Medicare Physician Fee Schedule—in a geographic HPSA. Incentives like loan repayment programs for physicians who agree to practice for a set period of time in rural areas or add-on payments such as the HSIP can encourage surgeons to practice in underserved areas and help address the maldistribution that currently exists in the workforce. While more analysis is needed to determine which levers and incentives work best to attract surgeons and other health professionals to where they are needed most, one study found that the HSIP was effective in increasing the number of surgical procedures performed in HPSAs relative to other facilities.³

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?

³ Surgical Procedures in Health Professional Shortage Areas: Impact of a Surgical Incentive Payment Plan, <https://www.sciencedirect.com/science/article/abs/pii/S0039606018301417>

Training more physicians in rural areas is one important way to help address ongoing provider shortages in these communities. Unfortunately, rural hospitals often operate with exceptionally tight margins, and Medicare GME only covers part of a hospital's costs to train residents. To help fill this gap, the ACS supports the *Rural Residency Planning and Development Act* (H.R. 7855), which would reauthorize the successful Rural Residency Planning and Development (RRPD) program for five years. The RRPD program, administered through HRSA, provides grants to help cover the startup costs associated with residency programs in rural areas and has supported 39 new accredited rural residency programs or rural track programs between 2019 and 2023.

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?

As you know, many sole community hospitals and Medicare-dependent hospitals only receive DGME funds and not additional IME funds that are available to other types of facilities. Not only does this limit the resources available to many rural hospitals, but multiple funding streams can also lead to inefficiencies and a lack of transparency.

The ACS has previously proposed that transitioning to a single stream of funding is an opportunity to increase efficiency, transparency, and accountability and to reduce physician shortages.⁴ However, given current and projected shortages in many specialties, we caution that this important reform should not be seen as an opportunity for reducing the federal support provided by Medicare. Rather, a single stream of funds for both IME and DGME managed by a regional governance body accountable for receipt of those funds, discussed below, could remedy much of the complexity inherent in the current system and is consistent with Medicare's policy goal of moving toward paying for quality and value.

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 ACS believes that the creation of a new body tasked with evaluating the distribution of GME slots would be beneficial. However, rather than a time-limited advisory council, the ACS has previously envisioned a regionalized GME system, under the auspices of an independent and permanent regulatory agency, charged with overseeing governance and training.⁵ The Federal Reserve System's central Board of Governors and its 12 regional Boards of Directors is an example of such a governance structure. Though able to operate somewhat independently, the Board of Directors would remain under the general policy oversight of the Board of Governors.

⁴ ACS Policy and Position Paper on GME Reform, January 2017, www.facs.org/media/zslljykl/2017_ahp_gmepaperappendixprimer.pdf

⁵ ACS Policy and Position Paper on GME Reform

In a regional governance system, training needs and funding decisions would be determined by the individual region's directors based upon workforce data and thus be reflective of unique population needs and workforce requirements. Such a regional governance structure has the potential to be much more nimble, responsive, and accountable to the needs of various regions of the country as members of the regional Board would be more familiar with the unique demographics of the population, regional practice patterns, and educational training resources available in their respective regions.

The ACS maintains that accurate and actionable workforce data must be the foundation of any effort to strengthen the nation's health care system and sees the current lack of data as one of the largest obstacles to achieving an optimal distribution of skilled health professionals. Thus, a primary function of the regional GME Board of Directors would be the regular collection of survey data on workforce needs, actual training costs, and changes in the medical marketplace within the specified region. All institutions and entities participating in training for the region would have individual roles to play and would bear some responsibility toward producing the appropriate physician workforce necessary to meet the population-based, demand-side needs as determined by the regional data collection and analysis.

Regionalization would facilitate targeted interventions to address shortages projected in specific geographic areas or specialties. If Congress does elect to create a time-limited GME Policy Council, it should also be tasked with exploring and reporting back on the merits of a system such as the one proposed by the ACS, as well as the current status of health care workforce data and any potential roadblocks in optimally allocating GME slots to achieve workforce and patient access goals.

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

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

As mentioned above, the ACS believes that the periodic, repetitive collection and analysis of workforce data on both a regional and national basis, undertaken in consultation with relevant stakeholders, is essential to improve the health care system. The task for policymakers is to understand where access issues are and direct needed resources, including GME slots, to those areas.

One step Congress can take to strengthen health care workforce data collection is to fully fund the National Health Care Workforce Commission ("the Commission") or an appropriate successor body. The Commission was established more than a decade ago as a multi-stakeholder body charged with developing a national health care workforce strategy, including reviewing current and projected health care workforce supply and demand and analyzing and recommending federal policies affecting the workforce. Unfortunately, this body was never funded and therefore has not been able to begin this important work. The ACS has long supported funding the work of the

Commission at a minimum of \$3 million, reiterating this request most recently for fiscal year 2025. Doing so will improve our understanding of health care access and workforce needs as well as provide a new opportunity for direct stakeholder engagement.

Current available data estimate the supply of surgeons needed in a given geographic area to provide an equivalent level of care to the current nationwide average. Unfortunately, these data are unable to indicate if the supply of surgeons in a given geographic area is adequate to provide access to the services demanded by the population. This is largely because there is no agreed upon definition of what constitutes a shortage of surgeons for a given population, and unlike other key providers of the community-based health care system, HRSA does not maintain a geographic shortage area designation for surgery. The ACS believes there is an urgent need to establish a surgical shortage designation. The *Ensuring Access to General Surgery Act* (S. 1140/H.R. 1781) would direct HRSA to study and define general surgery workforce shortage areas and collect data on the adequacy of access to surgical services, as well as specifically grant the agency authority to designate general surgery shortage areas. This designation could then be used to direct GME slots.

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?

Individual residency programs report on the ultimate board certification of their graduates as a measure of program success. This information is reported to the Accreditation Council for Graduate Medical Education (ACGME). We encourage Congress to work with ACGME when considering the development of additional reporting requirements, such as residents’ practice location after graduation. If additional reporting requirements are established, policymakers should ensure that they are not overly burdensome and that training institutions have the resources necessary to comply.

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?

There must be accountability and transparency built into the GME system, not only to certify that funds are being spent appropriately to support the training of physicians, but also to ensure quality and readiness of the physicians emerging from training. Although the ACS strongly believes that GME should continue to be supported as a public good, we acknowledge the significant concerns relative to inadequate accountability for a substantial proportion of the public funds directed at GME and again acknowledge the relative ease in accounting for DGME dollars versus accounting for IME payments. Unfortunately, the complexity and inherent opacity of the current system creates the perception that funds are being used to support activities unrelated to training a high-quality workforce. The ACS believes that the vast majority of GME funds are used for their intended purpose; there is, nevertheless, the need for enhanced transparency in order to accurately demonstrate that the funds expended are indeed used to support training.

We believe that the entities engaged in GME training should be accountable for producing both the proper number and specialty mix of graduates to meet the identified health care needs of the nation's population, as well as the quality and readiness of the graduates produced. Though such metrics should assuredly include well-established benchmarks, such as specialty board certification, the ACS suggests that in addition appropriate quality and readiness metrics for all physicians should include training in evidence-based medicine, shared physician-patient decision making, and provision of care to underserved populations. The ACS also suggests that additional appropriate metrics specific for surgeons could include video review of trainees in the performance specified core procedures, participation in registries and quality improvement programs provided by the appropriate surgical specialty societies, and participation in state-based or federal programs directed at improving value driven outcomes.

As discussed above, we have proposed to increase this accountability and transparency through a governance structure designed to allow national standards to be achieved through regional control. Regional boards would be tasked with achieving broad goals but would have flexibility in choosing which levers to use to meet those goals. Finally, as discussed above, the ACS believes that transitioning to a single stream of funding is an opportunity to increase efficiency, transparency, and accountability and to reduce physician shortages. The creation of objective cost reporting requirements, with clear delineations established as to what can be supported with a single stream of federal funds, would help to ensure that those funds are being used for the intended purpose.

Additional Considerations

The ACS acknowledges Congress' desire for additional investments in primary care and psychiatry. However, it is essential that policymakers consider the full range of medical specialties when addressing health care workforce challenges. A 2024 report by the Association of American Medical Colleges projects a shortage of up to 86,000 physicians by 2036, including a shortage of up to 19,900 surgical specialists.⁶ Though some would assert that the nation's predicted physician workforce shortage can be effectively remedied by addressing only the shortfall in primary care providers, this data clearly indicates that such a one-dimensional solution would leave patients with complex care needs without access to critical specialty care.

The ACS supports at least 50 new GME slots assigned to general surgery as a first step. A sufficient general surgery workforce is not only essential for patient access to surgical care, but also critical to rural health care access more broadly. A general surgeon brings an estimated \$1.05 million to \$2.7 million per year to a small hospital, contributing as much as 40% to the overall revenue.⁷ This can mean the difference between a rural hospital remaining open to provide a full range of

⁶ The Complexities of Physician Supply and Demand: Projections From 2021 to 2036, March 2024, <https://www.aamc.org/media/75236/download?attachment>

⁷ The Need to Prepare More Surgeons for Rural Practice Is Urgent, March 2024, <https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2024/march-2024-volume-109-issue-3/the-need-to-prepare-more-surgeons-for-rural-practice-is-urgent/#:~:text=Rural%20communities%20derive%20significant%20benefits,40%25%20to%20the%20overall%20revenue>

services to the community, or closing its doors. Additionally, without the ability to deliver surgical care, a rural hospital may have to turn away other patients, such as obstetric and emergency cases, that rely on surgical backup.⁸

The ACS urges Congress to address workforce needs across all specialties. Simply increasing the number of primary care providers would fail to satisfy the demand for specialists whose cognitive and technical expertise are needed to ensure ready access to the type of sophisticated medical care that the American public has come to expect.

Concluding Remarks

It is absolutely vital that GME training programs result in patient access to the highest quality physicians. While increasing the overall number of federally funded GME slots is one way to address the nation's health care workforce challenges, that alone is not sufficient. Policymakers must also take steps to accurately identify where shortages exist and incentivize physicians of all specialties to practice in those areas.

As discussed above, accurate and actionable workforce data is a critical prerequisite to any GME reform efforts. In addition, the ACS believes that a single stream of funds for both IME and DGME, managed by a regional governance body accountable for receipt of those funds, could remedy much of the complexity inherent in the current system. Finally, it is essential that policymakers consider the full range of medical specialties when addressing health care workforce challenges.

The ACS thanks the Bipartisan Medicare GME Working Group for its thoughtful attention to strengthening the Medicare GME program and looks forward to continuing to work with lawmakers on these important issues. For questions or additional information, please contact Matt Brown with the ACS Division of Advocacy and Health Policy at mabrown@facs.org.

Sincerely,



Patricia L. Turner, MD, MBA, FACS
Executive Director & CEO

⁸ General Surgery Contributes to the Financial Health of Rural Hospitals and Communities, <https://pubmed.ncbi.nlm.nih.gov/19944821/#:~:text=Rural%20hospitals%20and%20communities%20often,surgical%20care%20in%20rural%20areas.>