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January 31, 2025

The Honorable Bill Cassidy
United States Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable John Cornyn
United States Senate
517 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Michael Bennet
United States Senate
261 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Catherine Cortez Masto
United States Senate
520 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senators Cassidy, Cornyn, Cortez Mastro and Bennett:

The Healthcare Association of New York State, on behalf of our member nonprofit and public teaching hospitals, appreciates your engagement and commitment to strengthening the physician workforce and patient access to care via the Medicare Graduate Medical Education program. HANYS commends you for your willingness to continue the work started last year by the bipartisan Senate Finance Committee GME Working Group and appreciates the opportunity to provide additional feedback on this bipartisan draft legislation.

Our comments are arranged by section for consideration.

Section 2: Additional distribution of Medicare GME residency positions to rural areas and key specialties

30-slot cap for distribution

HANYS believes the 30-slot residency cap for an individual teaching hospital is sufficient. Congress must ensure that CMS allocates all available slots, as this will help address the current physician shortages our hospitals are experiencing.

Residency training generally takes between three and five years, so policymakers should consider that to fully fund the training of one physician and to continue a full complement increase, a hospital's program could require up to three to five GME positions. Therefore, HANYS supports the Association of Academic Medical Colleges' recommendation to implement a five-slot "floor" unless a program has applied for fewer than five slots. This will help ensure that there are enough GME slots for teaching hospitals to meaningfully expand their programs.

Number of slots provided

While HANYS appreciates the increase of 5,000 new Medicare-funded residency positions over five years, it falls short of meeting the needs of a growing and aging population. Over the last several years, Congress has passed legislation as part of the Consolidated Appropriations Acts of 2021 and 2023 that added 1,200 new full-time equivalent residency positions; however, more support is needed. In New York state, about half of teaching hospitals and academic medical centers train

more physicians than their allotted Medicare-supported residency slots. HANYS supports the AAMC's recommendation to increase the number of slots to 10,000.

In addition, HANYS continues to caution against earmarking slots for certain specialty distributions, since specialty-specific shortages are not evenly distributed nationally.

Per-resident amounts
HANYS shares the AAMC's concerns that the potential financial uncertainty and administrative burden created under the proposed PRA and bonus program could undermine your bipartisan efforts and disincentivize teaching hospitals from applying for these positions. Therefore, HANYS encourages more collaboration with stakeholders to explore options that would not disadvantage these hospitals from applying for these positions.

Definition of rural hospitals
HANYS appreciates the importance of distributing residency slots to rural providers. However, HANYS does not support the redefined rural definition to exclude hospitals treated as being located in a rural area.

Many hospitals treated as being in a rural area are longstanding, experienced teaching hospitals with established programs and a history of retaining physicians where they are trained and distributing these physicians to other parts of the country. These hospitals treat patients well beyond their border or state, including patients from rural areas. Many residents of rural communities rely on these hospitals for their care, given the lack of access to care or specialty services.

Priority for distribution to rural and underserved areas

HANYS does not believe that a hospital's location in a medically underserved area is a good prioritization criterion for these residency slot distributions. Based on lessons learned from the distribution of slots under Section 126 of the Consolidated Appropriations Act of 2021, most residency training takes place in areas that do not meet the requirements of being rural or MUA.

In prior comments on the Section 126 slots, HANYS and other stakeholders recommended that CMS consider both the geographic Health Provider Shortage Area and population HPSA to determine if at least 50% of the training occurred in a HPSA. We believe the intention of the CAA was to prioritize hospitals that serve HPSAs even if they are not located with the geographic boundaries of the HPSA.

Patients who are in a HPSA may choose a teaching hospital nearby but not located in a HPSA because needed services are not provided elsewhere or it is more convenient and closer to their residence. Therefore, HANYS believes that for prioritization purposes, hospitals serving populations that live in a MUA would be better than those located in a MUA.

Section 3: Encouraging hospitals to train in rural areas

HANYS fully supports remote supervision of residents, which will allow for better access to care and increase training opportunities. While we appreciate that CMS finalized a policy to permanently allow for remote supervision of residents in rural areas for both telehealth and in-person services, we believe it should be expanded to include all areas, not just rural.

HANYS supports allowing teaching physicians to use telehealth to supervise resident physicians beyond Dec. 31, 2025. In addition, we continue to urge Congress to make all telehealth provisions adopted during the COVID-19 pandemic permanent beyond Dec. 31, 2025, including:

- allowing all Medicare patients to access telehealth services regardless of geographic area;
- allowing homes and other sites to be originating sites for telehealth services for all Medicare patients;
- expanding which practitioners are eligible to furnish telehealth services to include physical therapists, occupational therapists, speech-language pathologists, audiologists, marriage and family therapists, and mental health counselors;
- removing the in-person visit requirement within six months of an initial behavioral or mental health service and annually thereafter, and instead allowing mental health professionals and prescribers flexibility in determining the type of visit and frequency at which patients need an in-person visit; and
- allowing hospital outpatient departments to continue to bill for outpatient therapy, diabetes self-management training, and medical nutrition therapy services when provided remotely to beneficiaries in both urban and rural areas, and to beneficiaries in their homes.

The telehealth flexibilities implemented by Congress showed how essential it is to allow physicians to provide efficient and quality patient care remotely as an alternative to in-person visits. Without permanent flexibilities, starting Jan. 1, 2026, Medicare telehealth will return to a rural-only benefit and won't be provided in urban areas, which will limit patient access to care.

Section 4: Establishment of a Medicare GME policy council

HANYS opposes the establishment of a new Medicare GME policy council to make recommendations to the HHS secretary regarding the distribution of future slots in areas and specialties projected to experience a physician shortage after the fiscal year 2032 and every five years after. This draft legislation would award 5,000 residency slots from fiscal year 2027 through 2031.

The Council on Graduate Medical Education already exists as a federal advisory panel that recommends several directives related to teaching programs to the HHS secretary and Congress. HANYS believes Congress should bolster COGME as opposed to establishing a new council since COGME has expertise in developing programs with high impacts on rural and underserved communities.

Section 6: Improvements to the distribution of resident slots after a hospital closes

HANYS does not support amending Section 5506 of the Affordable Care Act, which preserves resident cap positions from closed hospitals by removing the third prioritization requirement for hospitals in the same region of the country as the closed hospital. Residents like to stay in the area in which they train; it would be counterproductive to remove the regional category, particularly since one of the intents of the proposed legislation is to help support rural teaching hospitals.

Section 7: Improving GME data collection and transparency

HANYS believes the refined list of categories for collecting GME data is sufficient; teaching hospitals currently report these data through existing sources such as the Medicare cost report. We support transparency, appreciate the importance of data-driven decision-making and are encouraged by the language in this bill that states, "*the Secretary shall utilize existing data collected for administrative or other purposes…*"

While it is critical to ensure that small teaching hospitals are not overwhelmed with reporting requirements, it is important to note that *all* teaching hospitals, rural or urban, are required to report a significant amount of information, not just for the GME program. They spend hundreds of hours and significant dollars to meet these requirements. HANYS strongly opposes CMS creating any new requirements that would be duplicative or require unnecessary reporting for teaching hospitals.

Again, HANYS appreciates your continued interest in advancing additional Medicare GME proposals to help address the physician workforce shortage. As this work continues, we reiterate our strong opposition to using site-neutral payment cuts to offset the cost of new Medicare-funded residency slots.

Thank you for the opportunity to provide feedback on this draft proposal. If you have questions, please contact me at cbatt@hanys.org or 202.488.1272.

Sincerely,

Cristina Batt

Cristina Batt
Senior Vice President, Federal Policy