COGME
Council on Graduate Medical Education

August 20, 2021

The Honorable Xavier Becerra
Secretary of Health and Human Services
200 Independence Ave S.W.
Washington, DC 20201

The Honorable Patty Murray
Chair, Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Richard Burr
Ranking Member, Committee on Health, Education, Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Frank Pallone
Chair, Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Ranking Member, Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

Dear Secretary Becerra, Chairman Murray, Ranking Member Burr, Chairman Pallone, and Ranking Member McMorris Rodgers:

As the chair and vice chair of the Council on Graduate Medical Education (COGME), we are writing to express the Council's strong support for the provisions of Section 126 of the 2021 Consolidated Appropriations Act, as they apply to changes in federal funding of graduate medical education (GME). We wish to offer suggestions from the perspective of COGME to ensure that the expansion of GME slots provided for in Section 126 will help ameliorate existing disparities in physician workforce training and distribution between rural and urban areas.

Since its creation by legislation in 1986 (762 of the Public Health Service Act (42 U.S.C. § 294o)), COGME has provided oversight and offered recommendations on federal GME policy and investments, physician training and medical practice, and a broad range of health workforce issues. By its charter, COGME has the charge to make recommendations to the Secretary of Health and Human Services and Congress with respect to the supply and distribution of physicians in the United States, current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties, and policies concerning changes in the financing of GME programs.

Noting persistent and increasing disparities in health care access and health outcomes between rural and urban areas of the country, COGME developed a series of issue briefs focused on addressing the health care needs of rural populations and bolstering the rural health care workforce. In these briefs, the Council proposed a paradigm shift toward ambulatory care and team-based training to meet the health and social care needs of rural communities. COGME believes that the provisions of Section 126 align well with this shift, and if applied strategically and equitably could provide progress toward achieving the goal of increasing the rural physician workforce and improving access to care in rural communities.

Per Section 126, beginning in fiscal year 2023, 200 new GME residency positions will be made available annually, up to a total of one thousand. Furthermore, not less than 10% of these new positions must be distributed within each of the following categories: rural hospitals, hospitals already above their Medicare cap for residency positions, hospitals in states with new medical schools or new branches of existing medical schools, and hospitals that serve Health Professional Shortage Areas (HPSAs).

COGME welcomes the much-needed expansion of GME slots funded through the Centers for Medicare and Medicaid Services (CMS). The Council wants to assure that the Department of Health and Human Services (HHS) implements the provisions of Section 126 in a meaningful and equitable manner to support rural residency training that contributes to the development of a well-trained workforce for rural America. Because of the limited number of new slots available under Section 126 and the large number of eligible hospitals, the allocation of the new GME slots will be a complex process that impacts a wide range of stakeholders. COGME offers the following recommendations:

- That the Health Resources and Services Administration (HRSA) and CMS work together to identify legislative and rulemaking changes that would provide HHS with greater flexibility to respond to workforce shortages and better meet Congressional intent of bolstering health care access in underserved areas.
- That CMS consider the differential impact on communities in prioritizing the allocation of these new residency positions. Adding even a limited number of new slots in a rural area or a population- or geographic-based HPSA may greatly improve health care access and quality, whereas adding a similar number of slots in an eligible urban or other well-resourced area may have marginal impact.
- That CMS allocate these new residency positions to facilitate both the expansion of existing residency programs and the creation of new programs in order to meet residency program accreditation requirements. COGME understands that CMS has currently proposed limiting the distribution of the new GME slots to no more than one residency position per hospital per year. Such a process would create challenges for hospitals and other teaching centers in rural and underserved regions that are trying to create new GME programs, as it would not be sufficient to obtain accreditation.[*]
- That CMS draw on expertise that HRSA has gained in selecting health care organizations for Teaching Health Center Graduate Medical Education and Rural Residency Planning and Development awards. These programs provide a potential model for targeting rural training investments toward needed specialties in rural communities, including family medicine, internal medicine, pediatrics, public health and general preventive medicine, psychiatry, general surgery, obstetrics and gynecology, and dentistry.
- That CMS work with HRSA to refine the definition of *rural* used to allocate positions in a way that highly prioritizes rural hospitals and hospitals that serve health professional shortage areas.

[*]The Accreditation Council for Graduate Medical Education (ACGME) sets accreditation requirements for residency programs, which generally specifies a minimum number of residency positions to establish a core residency program. This minimum number varies by specialty as set by the ACGME Residency Review Committees. For example, family medicine accreditation requires at least 4 positions at each education level for a total of 12 resident positions, see p. 19: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_FamilyMedicine_2021.pdf?ver=2021-06-22-162614-143.

Furthermore, rural programs qualifying under the 10% annual allocation should train residents at rural clinical sites for at least 50% of their residency time and focus on training physicians who will remain in practice in rural communities.

Without these provisions, Section 126 may not sufficiently address the current and growing need for rural providers.

Lastly, COGME has engaged in several discussions about the impact of the COVID-19 pandemic, which has been felt across the country but more so in rural and underserved regions. COGME is concerned that the workforce stresses exposed by the pandemic response could worsen the physician shortage in rural areas, further constricting health care access. HHS will need to monitor the health care workforce as the country enters the post-pandemic stage to assess the need for further support and expansion. COGME stands ready to provide further information and recommendations as needed.

Sincerely,

/s/ Erin Patricia Fraher
Erin Patricia Fraher, PhD, MPP
Chair, COGME

/s/ Thomas Tsai
Thomas Tsai, MD, MPH
Vice Chair, COGME