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June 28, 2024

The Honorable Ron Wyden
Chairman
United States Senate
Washington, DC 20510

The Honorable Michael Bennet
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Marsha Blackburn
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy, M.D.
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable John Cornyn
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Catherine Cortez Masto
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bob Menendez
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Thorn Tillis
Committee on Finance
United States Senate
Washington, DC 20510

Dear members of the Senate Finance Committee Bipartisan Working Group on GME,

On behalf of our more than 150 member hospitals and integrated health systems, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide comments on the proposal by the bipartisan Senate Finance Committee working group on GME reform.

WHA was established in 1920 and is a voluntary membership association. We are proud to say we represent all of Wisconsin's hospitals, including small Critical Access Hospitals, mid, and large-sized academic medical centers. We have hospitals in every part of the state—from very rural locations to larger, urban centers like Milwaukee. In addition, we count close to two dozen psychiatric, long-term acute care, rehabilitation and veterans' hospitals among our members.

WHA Appreciates Lawmakers' Recognition of the Health Care Workforce Shortage

WHA annually publishes a Health Care Workforce Report that looks at current health care workforce trends and forecasts upcoming concerns, including in the physician realm. The 2024 report cited data from Kaufman Hall's October 2023 State of Healthcare Performance Improvement national study reports 63% of clinics and health systems struggling to meet demand for patient access to their physician enterprise and patients waiting 25% longer to see a primary care provider.

Wisconsin has undertaken a variety of strategies to mitigate physician shortages, including pursuing reforms that allow advanced practice providers to practice at the top of their license, passing reasonable medical malpractice caps on non-economic damages to disincentivize frivolous medical malpractice lawsuits, advocating for flexibilities in areas like telehealth that help stretch the workforce, and creating a public-private partnership with the State of Wisconsin to fund new residency slots that help us "Grow Our Own" physician workforce.

Progress is being made. For instance, Wisconsin experiences a net in-migration of physicians coming to Wisconsin to practice compared to physicians leaving Wisconsin to practice in other states. Wisconsin's balanced liability environment and the ability to offer medical school and GME residency positions in Wisconsin has been key to creating an environment that draws physicians to Wisconsin. Our physician workforce is growing, but not fast enough. Access barriers and increased wait times persist, especially in the rural areas that make up much of our great state.

For these reasons, we have been strong supporters of Congress lifting the cap on graduate medical education slots that persisted since 1996, up until the additional 1,200 slots added in the Consolidated Appropriations Acts of 2021 and 2023. We greatly appreciated the additional slots Congress added then and are further encouraged by the efforts of this bipartisan work group.

Deciding on a Numbers and Types of Slots

WHA and our members appreciate the opportunity more GME slots will provide to recruit and retain physicians to provide care in Wisconsin, and we support the proposed framework for prioritization of psychiatry (at least 15%) and primary care (at least 25%) for additional Medicare graduate medical education (GME) slots. This percentage leaves room to address specialty shortages that also impact access to care. As already mentioned, the WHA 2024 Wisconsin Health Care Workforce Report notes 63% of clinics and health systems are struggling to meet demand for patient access to their physician enterprise.

WHA supports the percentages proposed, and additionally ask that Wisconsin, and other rural states, be prioritized also for additional slots. As the 2023 WHA Workforce Report notes, the Wisconsin Council on Medical Education and Workforce projects that Wisconsin alone could face a shortage of 3,000 physicians by 2035. This seems to track with projections from HRSA that the U.S. could face a shortage of nearly 140,000 physicians by 2036. Thus, WHA has been a strong supporter of the Resident Physician Shortage Reduction Act (S. 1302/H.R. 2389), bipartisan, bicameral legislation that would add 14,000 Medicare-funded residency slots over the next seven years. This legislation would be a step in the right direction, though significant additional efforts and slots will likely still be needed.

Despite assertively increasing medical school enrollments and GME opportunities in the state Wisconsin still has wide swaths of primary care and psychiatry shortage areas. As of April 1,2024 the Kaiser Family Foundation (KFF) reported that the number of psychiatrists available to serve the population meet only 41% of Wisconsin's need. With 171 total Mental Health Care HPSA designations Wisconsin is 12th highest of all the states. Wisconsinites fare only slightly better in primary medical care, with 62% of need met, and 162 total Primary Care HPSA Designations. This illustrates the need for additional psychiatry slots. However, we must not look at this problem in a vacuum.

Creating new slots to train psychiatrists will not solve the shortage of available inpatient beds. Congress must also act on improving the reimbursement structure for inpatient behavioral health care. Wisconsin continues to experience a loss of inpatient beds due to unsustainable reimbursement by Medicare and Medicaid. Case in point, HSHS Sacred Heart recently closed in Eau Claire, Wisconsin, in part due to severe Medicare and Medicaid losses it sustained from its inpatient psychiatry program. How is such a hospital supposed to sustain programs that under-reimburse for costs associated with providing 24/7/365 access to care?

Additionally, rural hospital in southwest Wisconsin just announced it would stop accepting new geriatric psychiatry patients also due to funding sustainability challenges. This will create further stresses on the sole remaining hospital that has geriatric psychiatric inpatient beds; it will see its caseloads of under-reimbursed care increase because of the influx of more patients that were previously cared for at closed locations.

Simply put, if Congress does not address the inherently flawed Medicare and Medicaid reimbursement structure for inpatient behavioral health, hospitals will not be able to sustain these programs, which will create patient bottlenecks for care.

Federal Programs Must do a Better Job of Getting Slots to Actual Rural Hospitals

WHA has been concerned about the current distribution of the first 400 (of the 1,200 total) new slots. In adhering to the requirements of Section 4112 of the Consolidated Appropriations Act 2023, CMS is supposed to ensure that at least 10 percent of slots go to each of the four categories of 1) rural areas; 2) hospitals operating above their residency cap; 3) hospitals in states with new medical schools; and 4) hospitals serving health professional shortage areas (HPSAs).

WHA is concerned that this proposal will unnecessarily end up excluding hospitals that unfortunately no longer reside in HPSAs due to HRSAs misguided shortage designation modernization project that, while well-intended, is exacerbating challenges for rural hospitals. For instance, around 25 Wisconsin hospitals lost their HPSA designations at the start of 2024 due to the way the Health Resources Services Administration updated its HPSA renewal process. Ironically, this is coming at a time when hospitals report growing – not shrinking – health care workforce staffing challenges. Additionally, some applicants for these GME slots have reported their concerns that relying too much on HPSA scores has unfairly led to the exclusion of their GME slot applications from consideration and has further discouraged other interested applicants from expending resources on an application that is unlikely to result in an award.

Wisconsin has currently seen no new slots awarded, despite having multiple entities who clearly fit at least one, if not more, of the 4 criteria in statute. Indeed, data shows the majority of slots CMS awarded so far were not distributed to geographically rural hospitals, but rather, urban and suburban hospitals that serve rural patients. This is clearly not following Congressional intent.

More Can be Done to Help Grow Physicians in Rural Areas

HRSA's policies to remove hospitals from previously designated HPSAs will only exacerbate health care workforce and physician shortages in rural areas. Congress and federal agencies should explore how to allow truly rural areas experiencing a workforce shortage to maintain their eligibility for federal loan repayment programs rather than removing their workforce shortage area designation. WHA has worked with the WI Primary Care Office to find workarounds to losing a HPSA designation, such as applying for a governor's shortage designation. Unfortunately, such requirements place additional burden on hospitals' workforce in terms of understanding and executing filing requirements, or, even result in transferring physicians to eligible locations connected with the hospital, such as a rural health clinic. Federal programs should reform these programs to add flexibility and reduce the workforce burden on hospitals.

Additionally, programs like CONRAD 30 could be reformed to require physicians to stay longer in rural areas. For instance, WHA has heard feedback from its member hospitals that CONRAD 30 physicians often leave the community after the 3-year obligation has ended. Congress might consider reforming the program to require a longer stay in a rural location in exchange for waiving the standard VISA requirements that would require the physician to leave the U.S.

Demand for Slots, rather than a New Federal Council, Should Drive Slot Distribution

WHA is not optimistic that establishing a new Medicare GME Policy Council will improve the distribution of slots to specialties in shortage. How would a council of 9 people be expected to account for the varied needs of rural communities all across the country? How would the council be balanced to ensure certain regions that hold appointments do not wield undue sway on the council's recommendations, and further distribution of slots? Wisconsin has, unfortunately, experienced too many instances of being on the losing end of what becomes a political decision when such structures are created.

It seems more sensible for slots to be distributed based on the demand that is shown from entities that apply. For instance, WHA's members have recently expressed concern about the shortage of obstetricians and neurosurgeons. It seems reasonable that with this knowledge, our hospital residency programs could apply for such slots to help grow programs locally, or even partner with known programs in nearby states to support their application for growing successful residency programs in the hope of growing the supply of such specialty training opportunities expeditiously.

WHA Supports Allowing Hospitals with Low GME Caps Additional Time to Reset Their Caps

WHA supports more flexibility to support hospitals with extremely low GME caps triggered by the 1996 cap on GME slots. Two hospitals in Wisconsin, Bellin Health and HSHS St. Vincent in Green Bay had their caps unfairly set at less than 1.0 FTE due to them hosting medical resident "rotators" for very brief periods of time. We were extremely pleased to see Congress address this issue and agree it makes sense to allow such hospitals more time to build their residency programs if they so desire.

Improvements to Resident Slot Distribution for a Hospital that Closes

Wisconsin hospitals have a long tradition of collaboration, including in the cooperation and collaboration of our Wisconsin GME programs that compete for resident candidates to fill their positions. With the recent closure of HSHS Sacred Heart Hospital in Eau Claire, the Wisconsin Collaborative for Rural GME and other stakeholders stepped up to ensure that the 11 residents in Sacred Heart GME positions were assisted in finding Wisconsin positions. We appreciate the committee's provision to keep the requirement that CMS first distribute slots to hospitals in the same statistical area and state as the closed hospital and ask that this provision remain unchanged.

However, it seems unfair that these slots will only persist until the students graduate, after which point in time, the slots would go back into the pool. The hospitals that agreed to take on the challenge of incorporating these slots into their existing programs should get the benefit of maintaining these slots if they wish to do so.

Do Not Increase the Burden on Hospitals to Report

Rather than increasing the reporting burden on teaching hospitals we ask the committee to first consider the wealth of information already available. For instance, hospitals report a wealth of information to the Accreditation Council for Graduate Medical Education (ACGME). There is also information available at membership-driven organizations, such as the Association of American Medical Colleges (AAMC). AAMC's U.S. Physician Workforce Data Dashboard provides detailed statistics, over time and at a state level, on active physicians, and MD and DO students, residents and fellows.

WHA inquired of some of our members on the question of asking teaching hospitals to report additional information and one of our physician members said it was "terrifying" to think of the prospects of increasing the reporting burden in light of all the various reporting requirements on top of other burdensome medical record entry and prior authorization burdens.

WHA appreciates the opportunity to provide comments on this proposal.

Sincerely,

Ann Zenk
SVP Workforce and Clinical Practice