Illinois Health and Hospital Association

Dear Chairman Wyden and Sens. Menendez, Cornyn, Cassidy, Bennet, Tillis, Cortez Masto and Blackburn:

On behalf of our more than 200 hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to respond to the Bipartisan Medicare Graduate Medical Education (GME) Working Group's (Working Group) Draft Proposal Outline and Questions for Consideration. We appreciate your bipartisan efforts to expand GME and ensure that we have a sustainable physician workforce into the future.

Illinois' academic medical centers and 55 teaching hospitals train the next generation of physicians, care for the sickest patients and provide many specialized services to patients, such as trauma care, organ transplantation, burn care and neonatal intensive care. Currently, approximately 6,000 medical residents and fellows train in Illinois' academic medical centers and teaching hospitals, making Illinois among the leading states in training tomorrow's physician workforce. However, like the majority of states across the U.S., Illinois is predicted to have a significant physician shortage in the future, as 32% of the physician workforce are nearing retirement age. As a result, our teaching hospitals have continued to expand their residency programs, far beyond the support given by the Medicare GME program. Of the nearly 6,000 medical residents and fellows in Illinois, approximately 1,000 are unsupported by Medicare GME funding. Moreover, of the slots that are Medicare supported, Medicare covers approximately 22% of the overall training costs.

IHA appreciates that the Working Group is engaging with hospitals and other key stakeholders to thoughtfully consider how to more closely align Medicare GME support with the growing need.

To that end, we urge the Working Group to:

1. Closely examine CMS' over-emphasis on Health Professional Shortage Areas (HPSAs). Per statute, only one category out of four eligible categories requires that hospitals serve areas designated as HPSAs. Yet, in implementation, CMS has required a high threshold of training time to occur in HPSAs and instituted a HPSA score to prioritize residency slots across all four eligible categories. This reliance on HPSAs serves to minimize Congress' other objectives including the goals of expanding training slots for hospitals in rural areas and for those training above their cap. Moreover, HPSA designations fluctuate, which creates instability and administrative burden for hospitals that are required to track residents' training time in a HPSA. We would advocate that the Working Group urge CMS to observe the statutory intent set forth in the Consolidated Appropriations Act of 2023 which provided clear criteria that would allow more of our hospitals to compete for these slots.
2. Extend the ability of teaching physicians to use telehealth to supervise resident physicians beyond Dec. 31, 2024. In addition, we urge the Working Group to make all telehealth provisions adopted during the COVID-19 pandemic permanent beyond Dec. 31, 2024, or barring that, extend these flexibilities for a minimum of two years. These important flexibilities include:
    1. allowing telehealth access regardless of geographic area;
    2. permitting homes and other sites to be originating sites for telehealth services;
    3. 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;
    4. removing the in-person visit requirement within six months of an initial behavioral or mental health service and annually thereafter, allowing mental health professionals flexibility in determining what is best for each of their patients.
3. Support the bipartisan Resident Physician Shortage Reduction Act (S. 1302/H.R.2389) which would provide 14,000 new Medicare-

supported GME positions over seven years.

4. Avoid any cuts to Medicare payment in other areas. Given inflationary pressures, labor and supply cost increases and other challenges, hospitals cannot afford Medicare payment cuts of any kind. As stated above, Medicare already only covers approximately 22% of the costs of each resident slot. Medicare payment cuts in other areas, such as the so-called "site-neutral" payment cuts to hospital outpatient departments included in the Lower Costs, More Transparency Act (H.R. 5378), fail to take into account the increased costs associated with hospital-based care which result from many factors, including hospitals' 24/7 nature, standby capacity in the event of emergencies and provision of care to patients that are sicker than patient populations in other care settings. Furthermore, they would be counter-productive to the Working Group's goal of providing academic medical centers and teaching hospitals with additional resources to expand training opportunities.
5. Provide additional support to the Council on Graduate Medical Education (COGME) rather than initiating a new GME policy council. Teaching hospitals, medical schools and other key stakeholders are represented on COGME. Additionally, COGME already has the statutory authority to make recommendations to HHS and other entities on the supply and distribution of physicians in the U.S. as well as current and future physician shortages.

Thank you for your consideration.

Jennifer Koehler
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Illinois Health and Hospital Association (IHA)

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