Congress of the United States
Washington, DC 20515

June 8, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SE
Washington, DC 20201

Dear Administrator Verma:

We are writing to urge you to use your existing authority to grant Graduate Medical Education (GME) cap flexibility in rural and underserved areas. Specifically, we ask that you give residency and fellowship programs in those communities up to 10 years to build out before they reach their Medicare GME cap.

As a country, we are facing both supply and demand issues in regard to provider access. Over the past twenty years, the patient load for an average clinician has grown significantly, particularly in rural and dense urban areas with limited medical infrastructure and scarce resources, and the gap between how many physicians we have and how many we need continues to grow. Additionally, as the baby boomer population continues to age, increased medical care is needed at a time when older physicians are retiring rapidly – in the next decade, over a third of active physicians will be 65 years or older. This combination is adding to the existing physician shortage facing our communities.

In fact, by 2030, experts predict a national physician shortage ranging between 40,800 to 104,900.[1] Physician shortages result in reduced access to care for millions of Americans through longer wait times, increased travel for care, and preventable emergency department visits. For medically underserved regions, these access issues are even more exaggerated. Training a corps of qualified medical students in primary care, general surgery, geriatric subspecialties, and other areas of shortage, will be necessary if we intend to provide access to timely, high-quality, affordable, and culturally appropriate care.

The allocation of Medicare dollars can play a critical role in shaping the size and makeup of the physician workforce, primarily by supporting GME in rural and underserved areas. Geographical studies show that national physician distribution correlates with distribution of GME programs, and physicians tend to practice within 100 miles of where they complete residency training.[2] And yet from 2005-2015, only 1% of residents trained in a rural health system.[3]

The Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid (CMS) contribute considerably to the development of America's future health professionals and to physicians in particular. In a recent report, the Government Accountability Office estimated that HHS

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[1] The 2017 Update: Complexities of Physician Supply and Demand: Projections from 2015 to 2030. AAMC. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaeecb00/aamc_projections_update_2017.pdf.

[2] Fagan EB; Finnegan, SC; Bazemore, AW; et. al. *Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training* Am Fam Physician. 2013 Nov 15;88(10):704

[3] U.S. Government Accountability Office, *Physician Workforce: Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs*, 17-411, May 2017.

administers seventy-two health workforce programs with nearly three-quarters of HHS health workforce spending coming from Medicare GME programs.[4]

In fact, of the approximately fifteen billion dollars spent annually by the federal government on health workforce training programs, seventy-eight percent of that funding is directed towards GME, with Medicare payments accounting for eighty-five percent of that amount.[5] However, these contributions were limited in 1997 when Congress placed a cap on the number of residency spots that teaching hospitals could be reimbursed for through Medicare. For new GME programs, this cap is set after an initial five-year development period, a practice that hampers under-resourced providers who need more time to recruit qualified faculty, adapt facilities for teaching purposes, and raise funds.

Fortunately, the Secretary retains significant discretion regarding the establishment of these GME caps at new teaching hospitals, which allows "*proper flexibility to respond to such changing needs, including the period of time such programs would be permitted to receive an increase in payments before a cap was applied.*"[6] We urge you to exercise this authority to grant up to 10 years for residency and fellowship programs to build out in medically underserved areas.

There is no silver bullet for fixing the physician shortage in this country. We need to develop a multifaceted approach to modernizing graduate medical education to keep with our ever-evolving health care system, in order to ensure that everyone has access to high quality, affordable health care, regardless of where they live or how much money they make.

If you have question or would like additional information, please feel free to reach out to either of our offices. Thank you for your consideration and we look forward to working with you on this important issue.

Sincerely,

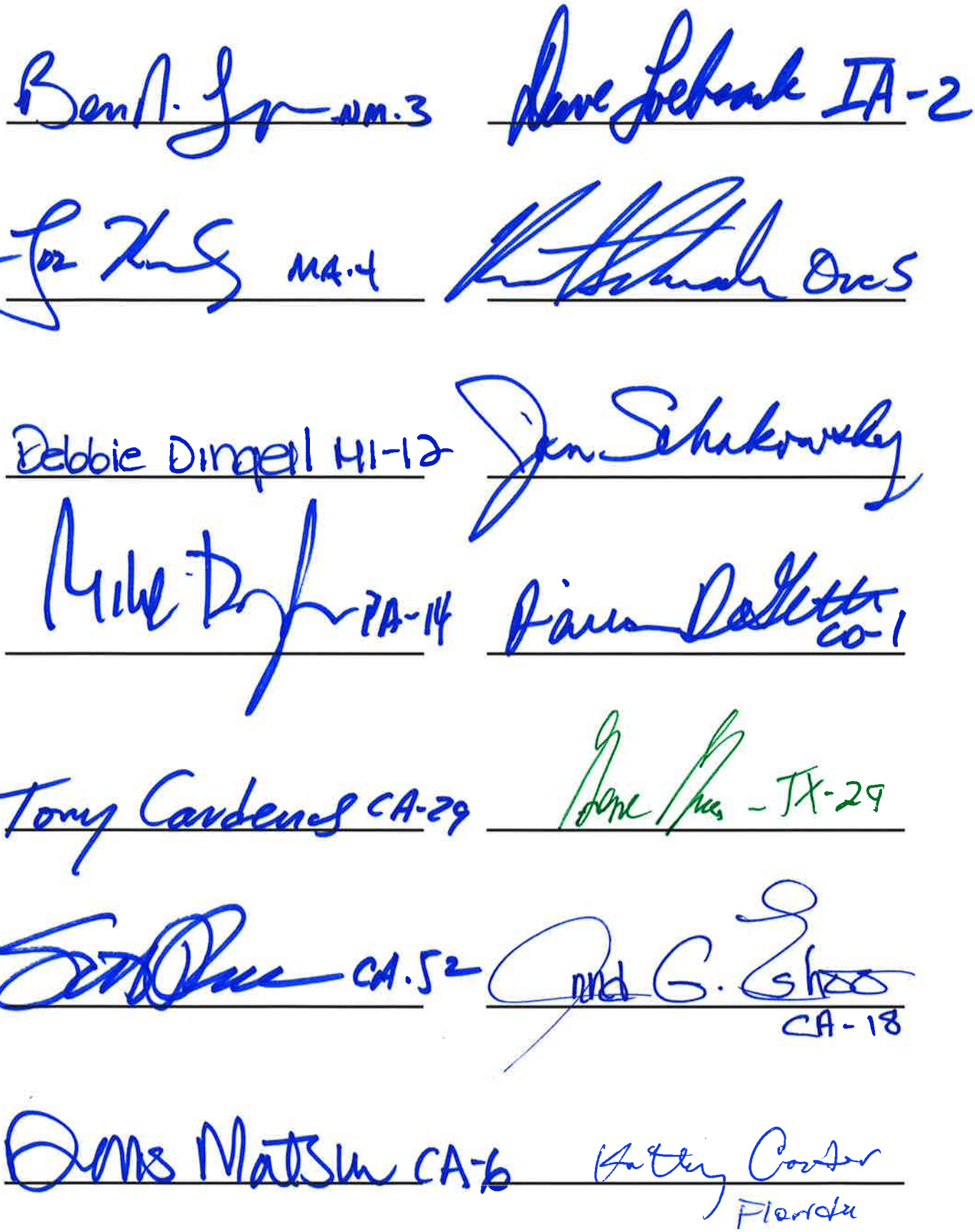
Raul Ruiz, M.D.
Member of Congress

Larry Bucshon, M.D
Member of Congress

[4] U.S. Government Accountability Office, *Health Care Workforce: Comprehensive Planning by HHS Needed to Meet National Needs*, 16-17, December 11, 2015, http://www.gao.gov/products/GAO-16-17; hereinafter, *GAO Health Workforce Planning Report*.

[5] GAO Health Care Workforce Report, pp. 5. The remaining amounts were from Medicaid 24%,

[6] U.S. House of Representatives. *Balanced Budget Act of 1997, Conference Report* (to Accompany H.R. 2015), pg. 820-822.


NM-3
IA-2
MA-4
OR-5
Debbie Dingell MI-12
PA-14
CO-1
Tony Cardenas CA-29
TX-29
CA-52
CA-18
Doris Matsui CA-6
Florida

Signatories

Aguilar, Pete (CA-31)
Brooks, Susan (IN-05)
Bucshon, Larry (IN-08)
Cardenas, Tony (CA-29)
Castor, Kathy (FL-14)
Carter, Buddy (GA-01)
Cole, Tom (OK-04)
Collins, Chris (NY-27)
Crowley, Joseph (NY-14)
DeGette, Diana (CO-01)
Dingell, Debbie (MI-12)
Doyle, Michael (PA-14)
Eshoo, Anna (CA-18)
Foster, Bill (IL-11)
Green, Gene (TX-29)
Griffith, H. Morgan (VA-09)
Gonzalez, Vicente (TX-15)
Hudson, Richard (NC-08)
Kelly, Robin (IL-02)
Kennedy, Joseph (MA-04)
Kihuen, Ruben (NV-04)
Kilmer, Derek (WA-06)
Loebsack, David (IA-02)
Long, Billy (MO-07)
Lujan, Ben Ray (NM-03)
Matsui, Doris (CA-06)
McMorris Rodgers, Cathy (WA-05)
Moulton, Seth (MA-06)
Mullin, Markwayne (OK-02)
O'Halleran, Tom (AZ-01)
Peters, Scott (CA-52)
Poliquin, Bruce (ME-02)
Roe, Phil (TN-01)
Ruiz, Raul (CA-36)
Schakowsky, Jan (IL-09)
Schrader, Kurt (OR-05)
Takano, Mark (CA-41)
Young, David (IA-03)