Congress of the United States
Washington, DC 20515

October 24, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

Physician shortages have long plagued the health care system in America, reducing access to primary care and specialist physicians, decreasing the quality of care for patients, and increasing wait times and travel distances to and from clinics. These effects are felt particularly strong in rural and underserved areas, a fact supported by years of data. As such, in the Consolidated Appropriations Act of 2021 (CAA 2021), in an effort to combat physician shortages and the communities they affect, Congress made historic investments in Medicare graduate medical education (GME). These investments were specifically intended to encourage physician training in rural communities. However, we write today with serious concern that these investments are not translating into increased access and better outcomes for seniors in rural and underserved communities, including those in Texas, Ohio, and North Carolina.

According to the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis, there will be a projected shortage of 81,180 full-time equivalent physicians in 2035, with such shortages occurring across all physician specialties in the United States. HRSA further states, "The percent adequacy of supply across all physician specialties is projected to be 48% in nonmetro areas (a shortage of nearly 52%), compared to 99% in metro areas (a shortage of just 1%) in 2035."[1] Therefore, according to HRSA's data, not only are there significant projected shortages across medical specialties, but there clearly is also a geographic misallocation of physicians and residency slots across the nation that will continue to grow unabated unless addressed.

In urology, for example, 72 percent of counties in America are limited to a single choice of urologist, half of all practicing urologists are over the age of 55, and a third are aged 65 and older. These are foreboding statistics; with a shifting physician and patient population and absent a streamlined and coherent provider pipeline in place, long-lasting negative economic and health implications will result. Moreover, caps placed upon GME programs, disproportionate allocation of funding, and the growing bureaucracy in health care have (and will continue to) significantly curtail the supply of physicians in certain geographic and medically underserved locations.

Congress sought to mitigate these workforce challenges in CAA 2021 by creating 1,000 additional Medicare-funded full-time equivalent (FTE) resident cap slots for eligible hospitals to be phased in over five years. Section 126 of CAA 2021 established a 10 percent minimum distribution for four categories of hospitals – with a focus on rural areas.

[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Physicians-Projections-Factsheet.pdf

On January 9, 2023, the Centers for Medicare & Medicaid Services (CMS) awarded the first round of 200 new residency slots, of which New York received 37 slots, more than double than any other state received. According to a press release, CMS "prioritized hospitals with training programs in geographic areas demonstrating the greatest need for additional providers, as determined by Health Professional Shortage Areas (HPSA)." As you know, HRSA HPSA data only tracks shortages in primary care, mental health, and dental health disciplines – leaving little visibility into general surgery, obstetric, specialty, and surgical subspecialty shortages.

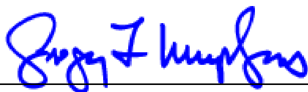
Finally, according to the data, of the 200 new residency slots, only five awardees are geographically rural, 42 are geographically urban and reclassified as rural, and 53 are geographically urban. We are concerned hospitals have taken advantage of previous regulations to reclassify from urban to rural for geographic purposes to gain a larger share of GME slots, while also receiving higher reimbursement by classifying their wage index back to urban. Given the aforementioned challenges, we are concerned current GME allocation methodologies are not serving Medicare beneficiaries as intended.

We are committed to working with you to prioritize the area of need for residency slots, decrease inefficiencies, and address outdated regulations to improve our provider supply chain. Please respond to the following questions by November 24, 2023:

- What is CMS' allocation methodology for the GME slots established in CAA 2021?
- Provide the number of applicants applying for GME slots under each of the four criteria laid out by Congress in the CAA 2021 and the number of these applicants that were ultimately awarded additional slots.
- Is CMS aware of hospitals reclassifying from urban to rural designations to receive GME cap slots while retaining urban wage index reimbursement?
- Did CMS award slots to any hospitals that reclassified and, as a result of the reclassification, were eligible for slots under the first category (location in a rural area, or being treated as being located in a rural area)?
    - If so, please provide the following information:
        - The number of such hospitals;
        - The name of each such hospital;
        - The city and state of each such hospital.
- Provide the number of applicants meeting all four requirements and the number of these applicants that were ultimately awarded slots.

Thank you for your assistance in this matter. If you have questions, please contact our staff at mclean.piner@mail.house.gov, kelsi.wilson@mail.house.gov, and chase.walker@mail.house.gov.

Sincerely,


Gregory F. Murphy, M.D.
Member of Congress

Brad R. Wenstrup, DPM
Member of Congress

Jodey Arrington
Member of Congress