Alliance of Specialty Medicine

25TH ANNIVERSARY

Sound Policy. Quality Care.

January 31, 2025

The Honorable Bill Cassidy, MD
455 Dirksen Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Catherine Cortez Masto
520 Hart Senate Office Building
United States Senate
Washington, DC 20510

The Honorable John Cornyn
517 Hart Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Michael Bennet
261 Russell Senate Office Building
United States Senate
Washington, DC 20510

RE: *Comments on draft legislation to improve the Medicare GME program*

Dear Senators Cassidy, Cortez Masto, Cornyn, and Bennet:

The Alliance of Specialty Medicine (the "Alliance") represents more than 100,000 specialty physicians and surgeons across 16 specialty and subspecialty societies and is deeply committed to improving access to specialty medical care through the advancement of sound health care policy. As patient and physician advocates, the undersigned organizations appreciate your efforts to advance Medicare graduate medical education (GME) proposals to address health care workforce shortages and gaps. We appreciate the opportunity to provide feedback on your draft legislation to improve the Medicare GME program. As specialty physicians, our comments are focused on the distribution of Medicare GME slots to rural areas, critical specialty shortages, and the establishment of a Medicare GME Policy Council.

Medical Specialty Workforce Shortages

According to the Association of American Medical Colleges (AAMC), the U.S. faces an overall shortage of up to 86,000 physicians by 2036 assuming future growth in the number of medical residency positions. However, in the absence of GME funding increases, AAMC explains that the projected shortfall closely resembles those presented in the 2021 report, i.e., a shortfall of 77,100 specialty and 48,000 primary care physicians by 2034.[1][2] Shortages will be particularly acute in the coming years for neurosurgeons, urologists, rheumatologists, ophthalmologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, dermatologic surgeons, orthopaedic surgeons, osteopathic surgeons, and general surgeons. For example:

[1] https://www.aamc.org/data-reports/workforce/report/physician-workforce-projections.
[2] American Association of Medical Colleges. *Summary Report: The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*. March, 2024.

- Thirty percent of the urology workforce is age 65 or older, making it one of the oldest in the medical profession.[3] By 2037, only 32% of the demand for urologists will be met in non-metropolitan areas, and only 82% of the demand will be met in metropolitan areas.[4]
- Over 50% of active gastroenterologists are nearing retirement age within the next decade; gastroenterology is anticipated to have the second-largest physician deficit, with a shortage of 1,630 FTEs, this year.[5]
- Demand for rheumatologists will exceed the number of practicing providers by over 100% by 2030 due to retirements and other workforce dynamics[6]

Addressing medical specialty shortages should be a part of any comprehensive workforce and GME policy reform, along with policies to address primary care and general surgery shortages. **It is especially critical to act now because specialty physicians require up to seven years (even longer if they pursue a post-residency fellowship) of post-graduate residency training** compared to three years for primary care physicians. Given the increased demand created for their services by an aging population and the concern that more physicians are leaving medical practice early due to burnout, Congress needs to take steps now to ensure a fully trained specialty physician workforce for the future. Such shortages not only overburden providers but can also cause longer wait times for patients and can prevent access to care in those areas with the worst shortages.

Comments on Draft Legislative Text

Sec. 2. ADDITIONAL AND IMPROVED DISTRIBUTION OF MEDICARE GME RESIDENCY POSITIONS TO RURAL AREAS AND KEY SPECIALTIES IN SHORTAGE.

The Alliance appreciates the steps taken by Congress to address the physician shortage crisis by approving 1,200 new Medicare-supported GME slots in the *Consolidated Appropriations Act, 2021* (P.L. 116-260) and the *Consolidated Appropriations Act, 2023* (P.L. 117-73). We thank you for recognizing that more changes are needed to ensure an adequate supply of physicians and allow the graduate medical education system to operate optimally.

The Alliance supports the addition of Medicare GME slots for each of fiscal years 2027 through 2031 and urges you to increase the number of slots available for distribution to 10,000 (P. 3, line 13) to ensure that a meaningful number of new slots are funded.

Additionally, **we encourage you to provide at least 25 percent of available slots for medical or surgical specialty or subspecialty residency** given that the health care system needs to optimize the training and availability of a robust workforce to fully meet the needs of Medicare beneficiaries.

To accomplish this, we suggest the following changes to the draft legislative text:

- P. 3, line 17 – after "RESIDENCIES" insert ";MEDICAL OR SURGICAL SPECIALTY OR SUBSPECIALTY RESIDENCIES"

[3] https://www.auanet.org/advocacy/federal-advocacy/workforce-shortages.
[4] https://data.hrsa.gov/topics/health-workforce/workforce-projections.
[5] https://medicushcs.com/resources/addressing-the-impending-gastroenterologist-shortage.
[6] Battafarano DF, Ditmyer M, Bolster MB, et al. 2015 American College of Rheumatology Workforce Study: supply and demand projections of adult rheumatology workforce, 2015-2030. Arthritis Care Res 2018;70:617-26.

- P. 4, line 6 – after "subparagraph);" insert
  '(cc) at least 25 percent shall be distributed for a medical or surgical specialty or subspecialty residency (as defined in subparagraph (F));"
- P. 14, line 20 – after "(iv)" insert "MEDICAL OR SURGICAL SPECIALTY OR SUBSPECIALTY RESIDENCY.—The term "medical or surgical specialty or subspecialty residency" means a residency program or other postgraduate medical training program, as described in paragraph (5)(A) for residents enrolled in an approved medical residency training program, other than primary care residency as described in (5)(H) and psychiatry or psychiatry subspecialty residency as defined in (10)(F)(ii)."
- Renumber subsequent subparagraphs accordingly.

The magnitude of the projected physician workforce shortage emphasizes the need to expand GME to train additional specialty care physicians. The Alliance believes that to produce the number of highly trained specialty physicians needed to treat an ever-expanding patient population, **Medicare must provide financial support for the entire length of training required for a resident's initial board certification.**

Preparing our medical workforce and ensuring medical education continues to evolve to meet advancing medical knowledge is critical to maintaining the standard of health care in this country. Access to high-quality and appropriate care is necessary to contain costs and effectively manage the progression of disease, chronic and complex conditions, and co-morbidities.

While it is imperative that primary care physicians and specialists work together to ensure the delivery of quality care, evidence indicates that specialists achieve better outcomes in the treatment of the diseases on which they focus. Physician shortages have led to a very precarious situation regarding the ability to train high-quality specialists who can treat such diseases in the near future. And, unlike primary care physicians, who receive full GME support for their three-year residency training, specialty physicians require up to eight (and sometimes nine) years of post-graduate residency training. By the time a true crisis manifests itself, we will be unable to correct it quickly. Thus, we need to take steps now to ensure a fully trained specialty physician workforce well into the future.

As discussed above, there are shortages in both specialty and primary care. Therefore, **we request that Sec. 2(b)(G)(v)(II) be amended to include "medical and surgical specialty and subspecialty physicians"** in the requirement for the Secretary to rank states based on the ratio of physicians to the total state population. Given the projected workforce shortages in specialty care, we believe it is crucial to address all areas of workforce shortages to best serve patients, many of whom face challenges in finding a new specialist.

Additional Feedback in Response to Specific Questions

2. Is codifying remote supervision the best way to provide flexibility to rural hospitals, or are there alternative approaches Congress should consider?

The Alliance believes that there should be incentives to train and develop a quality workforce, sufficient in numbers, for rural settings. Such opportunities should provide both primary and specialty medicine residents with diverse training opportunities to best prepare them for patient care. **Rotations in rural and underserved areas can help achieve this goal**.

However, it is important to recognize that certain specialties, such as neurosurgery, require significant resources (e.g., expensive technology and other high-tech medical equipment, neuro-ICUs, specialized nurses and other ancillary clinical personnel and services) that are not often found in rural and underserved areas. As such, these specialties may not be able to practice in rural or underserved areas. Thus, policies to incentivize physicians to serve these locations should be measured and flexible.

4. Is creating a GME Policy Council the right approach to guiding future GME slot allocations? Is the scope and responsibility of the Council adequate to make it effective?
The Alliance agrees that a better mechanism is needed to distribute Medicare GME slots to specialties in shortage that does not require congressional action. Exemplified by the more than 25 years it has taken to modestly increase the cap on GME slots, we need a more flexible and nimble mechanism to better respond to projected workforce shortages. As mentioned earlier, it takes many more years to train specialists than primary care physicians, and the delay in acting to address specialist workforce shortages can impact an entire generation.

The Alliance does not support the creation of a new GME Policy Council, finding it redundant and unnecessary. However, in response to the question above, the Alliance strongly recommends that any GME Policy Council include representatives of practicing medical specialists and specialty physician organizations. In addition, there needs to be a mechanism for public comment and submission of relevant data to fully understand workforce projections. An improved Council on Graduate Medical Education (COGME) could help facilitate this process.

The Alliance applauds your ongoing work to address the growing physician workforce crisis and encourages you to explore specialty physician workforce needs. Projected workforce shortages in many fields of medicine will jeopardize access to care for patients and will take time to address. Congress must act now to increase the number of residency slots to ensure access to care. We look forward to working with you on this important issue. Please contact us at info@specialtydocs.org if you have any questions or would like to discuss these issues in greater detail.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Association of Neurological Surgeons
American Academy of Otolaryngology – Head and Neck Surgery
American College of Osteopathic Surgeons
American Gastroenterological Association
American Society of Cataract and Refractive Surgery
American Society of Dermatologic Surgery Association
American Society of Echocardiography
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology