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January 16, 2015

The Honorable Joseph Pitts
United State House of Representatives
420 Cannon HOB
Washington, DC 20515

The Honorable Frank Pallone, Jr.
United States Representatives
237 Cannon HOB
Washington, DC 20515

RE: Open Letter Requesting Information on Graduate Medical Education

Dear Representatives Pitts and Pallone:

The American Urological Association (AUA) appreciates the opportunity to provide comments in response to your Open Letter requesting information on the financing of graduate medical education (GME). The AUA, founded in 1902, is the premier professional association for the advancement of urologic patient care, and works to ensure that its more than 18,000 members are current on the latest research and practices in urology. The AUA also pursues its mission of fostering the highest standards of urologic care by providing a wide range of services—including publications, research, the Annual Meeting, continuing medical education (CME) and the formulation of health policy.

The AUA offers the following responses to the specific questions you posed:

1. What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?

Eighteen years ago, Congress took steps to control GME spending by including provisions in the Balanced Budget Act of 1997 (BBA), which froze Medicare's support for physician training at 1996 levels. However, unless the number of funded residency training positions expands at the nation's teaching hospitals, the U.S. will face a declining number of physicians available to treat our nation's growing population. The AUA believes that the GME system should account for measured workforce shortages in relation to the growing population and disease burden. **Congress must eliminate Medicare's arbitrary cap on GME financing and provide support for all Accreditation Council for Graduate Medical Education (ACGME) approved residency training programs. If the goal of GME financing reform is to develop a sound and rational federal policy, the number of training slots should be based on the projected physician workforce needs of the US population.**

To best serve the public, the GME system must ensure that medical school



graduates are prepared to provide high quality care in each specialty of medicine upon the completion of residency training. It then follows that **the financing system should be better aligned with the current ACGME accreditation process – both at the institutional and program level.** Medicare does not currently provide full direct GME financial support for the length of training required for a resident’s initial board certification in several specialties. Full support is only provided for the first five years, and then the direct GME payment is reduced by fifty percent for years six and seven. According to the American Board of Urology, a doctor must be in residency for a minimum of five years before s/he may sit for certification. Those that subspecialize in a program like pediatric urology or urologic oncology may require an additional three years of clinical and research training. **It is imperative that GME funding be expanded to fully cover the entire length of training required for initial board certification.**

GME funding should be supported by all users of the health system. One proposal to consider would be to have all private payers contribute to a financing pool for GME and allow insurance companies to include such contributions as part of their medical loss ratio. State and local governments could also contribute funds to support GME needs, as much of the benefit from GME accrues to the population in the vicinity of resident teaching venues, which includes academic health centers, but also extends into the community and rural areas with teaching programs or affiliations with teaching programs. However, AUA notes that GME funding should be stable to allow for the multi-year training needs of a health care workforce.

- 2. There have been numerous proposals put forth to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?*

The AUA is supportive of the Association of American Medical Colleges’ (AAMC) *Physician Workforce Policy Recommendations*, which state that federally-supported GME positions should be increased by at least 4,000 a year with half of the slots going to increase the supply of specialists, including urologists.

The AUA finds it startling that the IOM’s report *Graduate Medical Education That Meets the Nation’s Health Needs: Recommendations, Goals, and Next Steps on Graduate Medical Education (GME)* does not mention increasing the number of GME slots. It is unclear to us why IOM would not make a concrete policy recommendation to address workforce shortages and to increase slots. Additionally, the report’s recommendation of creating a new GME “policy council” inside the U.S. Department of Health Human Services (HHS) and a “GME Center” within the Centers for Medicare and Medicaid Services (CMS) runs the risk of merely creating bureaucracies and delaying the training of new doctors needed to care for the growing patient population, while simultaneously



utilizing resources that could be dedicated to increasing the much needed supply of physicians in the workforce. The crisis of patient access to physicians reached tragic proportions at the Veterans Health Administration (VHA). Policymakers should take the lessons learned at the VHA and not the recommendation of the IOM report and apply them to rest of the patient population.

The AUA has voiced its support for the bipartisan “**Resident Physician Shortage Reduction Act**” and “**Training Tomorrow’s Doctors Today Act**” introduced during the 113th Congress. Both bills would improve the nation’s GME system and help to preserve access to essential health services for many Americans. These bills would increase the number of GME residency slots by 15,000 over the next five years and direct half of the number of newly available positions to training in shortage specialties, such as urology. Recognizing that both primary care providers and specialists are an integral part of American medicine, the AUA supports provisions in these bills for a report to study the needs of the U.S. healthcare system and allocate residencies accordingly.

3. Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

The AUA believes that there should be incentives to train and develop a quality workforce, sufficient in numbers, for rural settings and such opportunities should provide both primary and specialty medicine residents diverse training opportunities to best prepare them for patient care. Financial incentives could be provided through indirect GME payment for primary care and specialty medicine training programs in rural areas. Telemedicine funding for these centers and their rural patients for direct care and educational conferences could also be supplied and improve access to specialty care for rural residents.

Geographic distribution of urologists in the United States demonstrates the need for more attention to practice in rural areas. In rural settings, as defined by the Office of Management and Budget Metropolitan Statistical Area census, the average age of a urologist is on average 2.2 years older than a urologist practicing in an urban setting. As of 2009, the concentration of urologists practicing in an urban setting was 7 times higher than the number practicing in a rural setting. In addition, urologists practicing in a group setting increased to 60% of the entire workforce; whereas the number of urologists in solo practice decreased to 20%. In summary, the geographic trends favor younger urologists practicing in large groups within an urban setting. Urologists in the rural setting tend to be older and in solo practice nearing retirement. These data raise concerns that a disproportionate aging urology workforce significantly threatens access to urologic care, especially in rural areas, which comprise 18% of the US population, or roughly 54 million people. The ramifications of these trends can be far reaching as there is a statistically significant higher urologic cancer specific mortality rate for people living in a county not served by a urologist.



4. Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?

The current financing structure for GME is not appropriate to meet current and future healthcare workforce needs. Since Medicare's support for physician training was frozen at 1996 levels, many GME slots have been financed through philanthropy, hospital funds, and physician salaries. These are unsustainable sources of funding, and jeopardize patient access to quality care.

4i. Should it account for direct and indirect costs as separate payments?

The AUA believes that the financing structure of GME should account for direct and indirect costs as separate payments. Furthermore, indirect GME payments should take into consideration the necessary risk adjustment for severity of patient illness in academic teaching centers and training programs.

4ib. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsive to current and future workforce needs?

Current GME funding formulas should also take into account advances in resident education, specifically surgical simulation labs and robotic trainers. It is also necessary that additional funding be provided to support research that furthers our understanding of the relationship between a decreasing physician workforce and an increasing elderly population prone to a growing chronic disease burden.

4.ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

The magnitude of the physician workforce shortage projected emphasizes the need to expand GME to train additional specialty care physicians. The AUA believes that in order to produce the number of highly trained specialty physicians needed to treat an ever-expanding patient population, GME programs must provide financial support for the entire length of training required for a resident's initial board certification. As mentioned above, urological training requires a minimum of five years of residency, and those that subspecialize in a program like pediatric urology or urologic oncology may require an additional three years.

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 comorbidities.

While it is imperative that primary care physicians and specialists work together to ensure 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 years of post-graduate residency training. By the time a true crisis manifests itself, we will be unable to quickly correct it. Thus we need to take steps now to ensure a fully trained specialty physician workforce well into the future.

5. Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability, and quality?

The current system does not incentivize high quality training programs. The AUA believes that quality metrics could be used to measure the success of a particular program in the training of residents as a means to ensure program accountability to the public. One possible option would be to track the rate of residents who become board certified or board eligible as a proxy for determining whether medical specialty residents were trained in a high quality environment.

GME is a public good and is significantly financed with public dollars. Therefore, the GME system must be accountable to the needs of the public. Congress must maintain the linkage between GME funding and ACGME-approved training programs in order to ensure that our nation's residents continue to be trained through the highest quality programs, and GME must provide financial support for the entire length of training required for a resident's initial board certification.

Furthermore, institutions should be held accountable to program directors for reporting GME funding at the program level and establishing a clear appeals process if funding is withheld or diverted at the institutional level.

6. Is the current system of residency slots appropriately meeting the nation's healthcare needs?

While AUA acknowledges the need to increase the number of available primary care providers, this only addresses part of the problem. Based on current estimates from the



AAMC, the overall shortage will be approximately 130,600 physicians by 2025 – one-half of which, or 64,800, are specialty physicians, including urologists. And unlike primary care physicians whose residency training is only three years, specialty physicians require up to eight years of post-graduate residency training; thus we need to take steps now to ensure a fully trained specialty physician workforce well into the future.

Recent surveys have highlighted that, by 2020, urology will face a severe shortage primarily related to increased demand of the aging population¹ as well as previous resident restrictions. Correcting this workforce shortage is of vital importance in order to maintain the availability of urological services to meet the needs of our aging population, for whom the rates of obesity and chronic diseases like diabetes, rheumatoid arthritis/osteoporosis, prostate and bladder cancer, BPH, urinary retention, and kidney disease continue to rise. One in every five primary care visits in the United States involves a urologic condition. Urologists treat many conditions that involve the urinary and reproductive tract of both men and women. We provide medical and surgical treatment for prostate cancer and bladder cancer, two of the four most common cancers diagnosed in US men and kidney cancer, the seventh most common cancer diagnosed in US men and women. We also treat men with enlarged prostate and urinary difficulties, urinary incontinence in men and women, stones of the urinary tract, infections of the urinary tract, erectile dysfunction in men, and infertile couples.

While we are aware of concerns related to a shortage of primary care physicians, **we want to ensure you have key data related to shortages in urology, as well as particular training challenges that increase the costs of training. Urology has seen a greater than 10% decline in the number of urologists per capita over the past twenty years, which is amongst the greatest of all surgical sub-specialties.** In 2009, there were only 3.18 urologists per 100,000 population, which marked a thirty-year low in the labor force for our field. The average age of a urologist is 51 years, with 38 percent of urologists age 55 or older.

This contracting urology workforce is impacted by an aging US population that will require more health care services. By 2030 it is estimated that nearly 20% of the population will be 65 years or older. These elderly patients will require as much as three fold the rate of surgical services that the general population consumes. To meet the demands of these population estimations, the Health Resources and Services Administration Bureau of Health Professions, in its 2008 report, projects a need of 14,000 urologists by 2015 and 16,000 urologists by 2020. Instead, several projections have estimated that the US will have less than 8,000 urologists by 2020. These data are congruent with other independent projections that show that by 2030 urology will face a 32% (3,884 urologists) deficiency in the number of providers necessary to adequately care for a projected 364 million US citizens.

¹<http://www.physiciansnews.com/spotlight/304.html>



As mentioned in response to question #3, another concerning trend is the geographic distribution of urologists in the United States. In rural settings, as defined by the Office of Management and Budget Metropolitan Statistical Area census, the average age of a urologist is on average 2.2 years older than a urologist practicing in an urban setting. As of 2009, the concentration of urologists practicing in an urban setting was 7 times higher than the number practicing in a rural setting. In addition, urologists practicing in a group setting increased to 60% of the entire workforce; whereas the number of urologists in solo practice decreased to 20%. In summary, the geographic trends favor younger urologists practicing in large groups within an urban setting. Urologists in the rural setting tend to be older and in solo practice nearing retirement. These data raise concerns that a disproportionate aging urology workforce significantly threatens access to urologic care, especially in rural areas, which comprise 18% of the US population, or roughly 54 million people. The ramifications of these trends can be far reaching as there is a statistically significant higher urologic cancer specific mortality rate for people living in a county not served by a urologist.

Mirroring this nationwide shortage of clinical urologists, a recent survey done by the AUA of its members of the academic urologic workforce projected that over 369 faculty positions will need to be filled over the next five years. This fact suggests that a shortage of academic urologists, the prime educators of urology GME, is even more profound than that of independent practice urologists. **The Society of University Urologists (SUU) surveyed their membership to better understand the issues surrounding resident training. Fifty-four percent of respondents noted that their programs currently had unfunded residency positions, and sixty-five percent said that funding is an obstacle to adding new residency positions.** The main financial support engines used to supplement these resident positions are hospital funds and clinical revenue, the latter of which is no longer sustainable as clinical reimbursement dollars continue to decrease.

Furthermore, the ACGME initiatives have placed many new mandated requirements on urology training programs, including specific restrictions on **resident duty hours**. There is now a more focused emphasis on didactic teaching and independent learning opportunities, which are provided primarily through organized proficiency training labs. These new methods have proven costly, and are not supported by existing GME funds.

The current system of GME funding for urology residency programs is not sustainable. With 10,000 seniors aging into the Medicare program every day for the next 18 years, and 30 million new patients entering the system through the Affordable Care Act (ACA), the need for the services of trained urologists will increase significantly. The severe urology workforce shortage, in combination with a cap on GME funding, have led to a very precarious situation regarding the ability to train high quality urologists in the near future. There has been a 2% decline in the number of accredited urology residency programs since 2001, and a 19.7% decline in the number of urology residents achieving American Board of



Medical Specialties certification from 2000 – 2009 (2010 ABMS Certification statistics). **The American Urological Association is committed to training the highest quality residents; however, the current GME funding for resident education cannot meet the requirements necessary to accomplish this goal.**

7. Is there a role for states to play in defining our nation's healthcare workforce?

States could become more involved in GME through studying and tracking their residents' access to providers. Massachusetts, for example, has been successful in highlighting those areas where there are critical workforce shortages through the annual Massachusetts Medical Society Physician Workforce Study (<http://www.massmed.org/workforce2013>). This study delivers current and trend data on physician shortages in Massachusetts, including issues with physician recruitment and retention. Also, it examines the market conditions for specialties, willingness of residents and fellows to practice in the state, the impact of medical liability fees, and physician satisfaction. State involvement in this way would help ensure that the federal government is aware of each state's unique needs. The Massachusetts Medical Society study notes that urology has "consistently been classified as either operating in critical or severe labor markets over the past number of years."

In addition, as stated above, State and local governments could also contribute funds to support GME needs, as much of the benefit from GME accrues to the population in the vicinity of resident teaching venues. Also, Medicaid patients are often treated at teaching facilities and are therefore beneficiaries of teaching programs which provides a sound rationale for continued or increased state Medicaid program contributions to GME financing.

Many specialties like urology are already facing workforce shortages, and projections show that the problem is only going to get worse. It takes more than twelve years to produce a specialist, and by the time a true crisis is visible, we will be unable to quickly correct it. As our nation's population ages, access to high quality and appropriate care is necessary to contain costs and effectively manage the progression of disease, chronic conditions and comorbidities. 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.

Given the acute shortages of specialty physicians, and the demand created for their services by an aging population and expanded insurance coverage, AUA would like to encourage you to consider the workforce shortages in specialty medicine and urology. Projected workforce shortages in many fields of medicine will jeopardize access to care for patients



American Urological Association

and will take time to address. Congress must act now to increase the number of residency slots to ensure access to care.

Thank you for considering our comments and for your leadership on this issue. Please contact Brad Stine, Director of Government Relations and Advocacy, at 202-403-8503 or bstine@AUAnet.org if you have any questions.

Sincerely,
Christopher M. Gonzalez, MD, FACS

A handwritten signature in black ink, appearing to read "C. Gonzalez".

Chair, AUA Workforce Workgroup

CC: Rep. Gene Green, Rep. Diana DeGette, Rep. Cathy McMorris Rodgers, Rep. Peter Welch, Rep. H. Morgan Griffith, Rep. Kathy Castor