Alliance of Specialty Medicine

Sound Policy. Quality Care.

January 16, 2015

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

The Honorable Frank Pallone, Jr.
United States House of Representatives
237 Cannon House Office Building
Washington, DC 20515

RE: Open Letter Requesting Information on Graduate Medical Education

Dear Representatives Pitts and Pallone:

The Alliance of Specialty Medicine appreciates the opportunity to provide comments in response to your Open Letter requesting information on the financing of graduate medical education (GME). The Alliance is a coalition of national medical societies representing specialty physicians in the U.S. and is dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

In recent years, the Alliance has made an increased effort to draw attention to the physician workforce shortages within the entire physician community, but especially those related to specialty medicine. To this end, last year the Alliance hosted a physician policy roundtable on this issue in the U.S. Capitol and heard from representatives of the Association of American Medical Colleges (AAMC), the Institute of Medicine (IOM) and Congress who acknowledged that the **physician shortage crisis includes documented shortages in both primary and specialty medicine.** It is, therefore, essential that any changes to GME policy recognize physician workforce needs across the entire spectrum of medicine.

The Alliance 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. **Congress must eliminate Medicare's arbitrary cap on GME financing and provide support for all 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 U.S. 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. **It is imperative that GME funding be expanded to fully cover the entire length of training required for initial board certification.**

This **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.

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?***

We believe workforce and GME policy should focus both on primary care and specialty shortages. The Alliance is supportive of the AAMC's 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.

The Alliance 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 Alliance 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. Recognizing that both primary care providers and specialists are an integral part of American medicine, the Alliance 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 Alliance believes that there should be incentives to train and develop a quality workforce, sufficient in numbers, for rural settings and that such opportunities should provide both primary and specialty medicine residents diverse training opportunities to best prepare them for patient care.

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 Alliance believes that in order to produce the number of highly trained specialty physicians needed to treat an ever-expanding patient population, GME 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 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 correct it quickly. 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?***

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.

The ACGME, which serves as the accrediting body for more than 8,800 medical residency programs, is charged with setting and enforcing standards to ensure that trainees obtain the needed skill sets through innovative training that will better prepare residents for a changing practice environment. ACGME has demonstrated time and time again that it is the single most qualified entity to oversee and govern GME in the United States. Working with its Residency Review Committees and other stakeholders in the GME enterprise, the ACGME is a dynamic body that continues to promote an education and training paradigm that is patient-centered, efficient, effective, and adaptable to the ever-changing needs of a diverse population. **It is, therefore,, essential that the ACGME retain its preeminent role in overseeing resident training and graduate medical education.**

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?

The Alliance is deeply concerned about the workforce shortages projected in the near future for all physicians. While we acknowledge the need to increase the number of available primary care providers, this only addresses part of the problem. **Based on current estimates from AAMC, the United States will face a shortage of more than 130,000 physicians by 2025. Half of this shortage will come from specialty physicians, including neurosurgeons, urologists, cardiologists, gastroenterologists, plastic and reconstructive surgeons, and orthopaedic surgeons.**

The U.S. Health Resources and Services Administration (HRSA) Bureau of Health Professions (BHP) has cited significant workforce challenges across the surgical specialties. Between 2005 and 2020, BHP projects an increase of only 3 percent among practicing surgeons – with projected significant decline in a number of surgical specialties. Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.

A 2008 report by the HRSA found that by 2020, ophthalmology and orthopedic surgery are each expected to need more than 6,000 physicians over current levels, while other specialties like urology will see shortfalls of more than 4,000 physicians.

For eleven years in a row, the Massachusetts Medical Society has conducted a physician workforce study. The most recent report, conducted in 2012, identified seven physician specialties that meet the classification for critical or severe conditions in the labor market. **Urology and neurosurgery are considered to be in critical shortage, and gastroenterology is considered to be in severe shortage. An additional nine specialties have been operating within tight or tightening workforce shortages.**

With 10,000 seniors aging into the Medicare program every day, the growth in future demand for physicians will be highest among specialties that predominately serve the elderly. The Council on Graduate Medical Education (COGME) has also found that such shortages disproportionately impact rural areas, which are already underserved in specialty care. These acute shortages of specialty physicians will only worsen given the aging physician population and the increased demand for specialist services due to expanded insurance coverage. We also note that current physician shortage projections are based on the assumption that currently practicing physicians will retire at the normally expected age of retirement. However, it is entirely possible that the number of early retirements will be increasing, largely due to intensifying workplace stresses , declining reimbursements, and increasing regulatory burdens. 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.

The Alliance is concerned that current physician workforce policy fails to adequately recognize current and projected specialty shortages. This problem can in part be attributed to the fact that the total number of practicing specialists is often misunderstood or overstated. According to the Accreditation Council for Graduate Medical Education (ACGME), over half of ACGME residents and fellows are not likely to subspecialize.

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.

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.

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The Alliance appreciates any discussion on the growing physician workforce crisis, and we applaud this Committee's efforts to evaluate graduate medical education financing and the severe physician workforce shortage. The Alliance encourages you to explore specialty physician workforce needs and to pursue comprehensive workforce policy to support medical education for primary and specialty physicians. 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 feel free to reach out to us should you need additional data or information related to specialty shortages.

Sincerely,

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions
Society for Excellence in Eyecare

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