



January 16, 2015

The Honorable Fred Upton
Chair
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Upton and Ranking Member Pallone:

The American College of Physicians appreciates the opportunity to provide comments regarding graduate medical education (GME). The American College of Physicians is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 141,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. ACP feels strongly that the GME system should ensure that the nation has an adequate supply of the types of physicians needed to treat patients, that they enter the workforce with the knowledge and skills required to provide the highest quality care, and that all Americans have access to such care. The nation will not be able to expand access, improve health outcomes, and decrease health care expenditures without a national health care workforce policy and the appropriate direction of funding to achieve these goals.

The College is especially concerned about the shortage of primary care physicians in the United States, particularly the supply of internal medicine specialists and its impact on access to and delivery of high quality, lower cost health care. Internal Medicine specialists are at the forefront of managing chronic diseases and providing comprehensive and coordinated health care. The skills of internists will be increasingly necessary in taking care of an aging population with a growing prevalence of chronic diseases. The availability of physicians providing primary care in a community is consistently associated with better outcomes at lower costs.

The demand for primary care in the United States is expected to grow while the nation's supply of primary care physicians is dwindling and interest by U.S. medical school graduates in pursuing careers in primary care specialties is steadily declining. The reasons behind this decline in primary care physician supply are multi-faceted and complex. Key factors include the rapid rise in medical education debt, decreased income potential for primary care physicians compared to other specialists, and increased administrative requirements that have caused great dissatisfaction with the current practice environment. These barriers must be addressed

simultaneously and swiftly in order for the nation to meet the demand for the number of primary care physicians necessary to care for the U.S. population.

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

The College feels strongly that Medicare should maintain its commitment to GME, and that funding should be prioritized based on the nation's health care workforce needs.

- Currently, the types of residents trained in teaching hospitals are determined by the staffing needs of the particular hospital and the number of funded positions set by the cap in 1996. Although Medicare GME funds are supposed to help develop the future physician workforce, teaching hospitals are not required to consider local, regional, or national workforce needs, perhaps because the nation lacks a national health care workforce policy. These policies should include sufficient support to educate and train a supply of health professionals that meets the nation's health care needs and specifically to ensure an adequate supply and spectrum of primary care physicians trained to manage care for the whole patient.
- The College was encouraged by the establishment of the National Health Care Workforce Commission, charged with evaluating the nation's health care workforce needs and providing recommendations to Congress and the Administration on national health workforce priorities, goals, and policies and is dismayed that it has not received funding to begin its work. A thorough assessment of the supply, specialty mix, and distribution of physicians is necessary, and Medicare GME dollars should be used to address any shortcomings. ACP supports strategic increases in the number of Medicare-funded GME positions in primary care and other specialties facing shortages including many internal medicine subspecialties.

While changing the way existing GME dollars are distributed is important, Medicare GME-funding limits on residency training positions will continue to impede the establishment of new residency programs and additional training positions in existing programs.

- Medical schools have done their part to expand class sizes, but this will not increase the total number of U.S. physicians unless GME capacity is increased as well. ACP has considered the option of increasing the number of overall GME positions to increase the supply of physicians but concluded that these options would not ensure that adequate numbers enter and remain in practice in adult primary care and in other specialties facing shortages, including many subspecialties. Another option some have suggested is to limit federal Medicare GME funding only to "first certificate" programs, which we cannot support because it would have the impact of eliminating all federal GME funding of internal medicine subspecialty training programs. Elimination of such funding for training in internal medicine subspecialties training programs would undermine the goals of having well-trained physicians in these critically important subspecialty areas and contribute to a growing shortage of physicians in many of these fields.
- The imperative of deficit reduction suggests that federal government funding for GME could be more effectively targeted and prioritized to fields with the greatest and most

critical needs to train more physicians to meet national workforce goals. ACP accordingly recommends a targeted approach, recognizing the nation's increasing demographic demands for health care and the dwindling supply of primary care physicians and other specialties facing shortages.

The College also believes the costs of financing GME should be spread across the health care system and that all payers should be required to contribute to a financing pool to support residencies that meet policy goals related to supply, specialty mix, and site of training.

- While Medicare and other federal programs should continue to make a significant contribution to the financing of GME, an all-payer system would ease the obligation on Medicare and taxpayers and provide a more steady and predictable funding stream. The supply and distribution of physicians affects the availability, cost, and quality of care for all Americans. As such, the cost should be borne by all payers. GME is a public good— it benefits all of society, not just those who directly purchase or receive it. All payers depend on well-trained medical graduates, medical research, and technical advances from teaching hospitals to meet the nation's demand for a high standard of care. ACP believes that all payers derive value from this system and should share the investment in education and research. All payers should be concerned about preserving the nation's system of GME, that high standards of quality for patient care services are maintained, and that opportunities for entry into the medical profession are available to the best-qualified candidates. A mechanism should be established to require all payers to explicitly contribute to GME.

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

In the 113th Congress, ACP supported legislation that was introduced in both the House and Senate that would increase the number of Medicare-funded training positions for medical residents who choose careers in primary care. These bills are summarized below.

- The Resident Physician Shortage Reduction Act, S. 577, H.R. 1180, introduced by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY) and the Resident Physician Shortage Reduction Act, H.R. 1201, introduced by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), would provide for approximately 15,000 additional GME positions for medical residents and require at least 50 percent of the new positions to be allocated to specialties, such as primary care, that face a shortage. We believe the modest expansions in these bills are an essential step toward addressing the impending shortage of primary care physicians and other specialties facing shortages.
- H.R. 1201 would also establish and implement procedures under which payment for indirect medical education is adjusted based on the reporting of quality measures of patient care specified by the Secretary of Health and Human Services. ACP believes that the concept of a performance based GME payment system is worth exploring but cautions such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in primary care training. Hospitals

should be allowed sufficient time to prepare for the measures before financial incentives are introduced so that they do not risk losing funding at a time when they may need it the most in order to meet the performance standards. In addition, it should not be assumed that simply instituting performance metrics will result in improved medical education and/or progress toward workforce goals.

The College appreciates the Institute of Medicine (IOM) efforts to review the governance and financing of graduate medical education (GME) and supports the IOM's emphasis on accountability, innovation and transformation, including a greater emphasis on training in community-based settings, although we have significant concerns about some of the IOM report.

- We are very concerned that reducing GME payments to existing programs to fund innovation and transformation could do great harm to the educational mission of many teaching hospitals and the patients they serve.
- In addition, ACP is very concerned that the IOM did not make recommendations that address the nation's looming physician workforce crisis and is particularly concerned that the IOM stated that it "did not find credible evidence" to support claims that the nation is facing a looming physician shortage, particularly in primary care specialties.
- Although we concur with the IOM that more research is needed to guide physician workforce policies and that incentives, including payment reform, are needed to encourage careers in primary care, we believe there is credible evidence of a real and growing shortage of primary care physicians for adults warranting immediate action. Further, ACP agrees with the IOM that GME is a public good and is disappointed that the IOM did not call for an all-payer GME financing system to support this public good.

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?

As stated previously, the College feels strongly that Medicare GME funds should be prioritized based on the nation's health care workforce needs.

- According to the Health Resources and Services Administration (HRSA), there are 6,100 Primary Care Health Professional Shortage Areas (HPSAs) with over 60 million people living in them. An estimated 16,000 practitioners are required to meet their need for primary care (a population to practitioner ratio of 2,000:1).
- Physicians tend to stay to work in the area where they were trained, so Medicare GME dollars should be weighted to favor training programs in rural and underserved areas. Students from rural areas are more likely to practice in rural areas than those from urban areas. Weighting or shifting GME dollars to programs in areas of the country where physicians are needed most might lead to an increase in training positions in underserved areas, and a change in the distribution of physicians once their training is completed.

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

As noted earlier, the College believes that Medicare should maintain its support for GME as reducing GME payments to existing programs could do great harm to the educational mission of many teaching hospitals and the patients they serve. The College also feels strongly that Medicare GME funding should be prioritized based on the nation's health care workforce needs.

- Currently, teaching hospitals are not required to consider local, regional, or national workforce needs. Data suggest that teaching hospitals have favored higher revenue-generating specialty training over primary care positions by expanding positions in the "R.O.A.D." disciplines (radiology, ophthalmology, anesthesia, and dermatology) and emergency medicine. The expansion of these programs over the past ten years parallels losses in positions in primary care specialties.
- Primary care training programs should receive enough funding to develop the most robust training programs and meet RRC mandates. In addition, programs should be allowed to invest in better ambulatory experiences for trainees without being tied to fulfilling the patient care needs of the hospital. As programs adopt more innovative training models and increase exposure to well-functioning ambulatory settings, sufficient funding will be necessary to invest in training and development of primary care faculty.

The College also supports reauthorization and full funding of the Teaching Health Centers Graduation Medical Education (THCGME) Program.

The THCGME Program provides primary care medical and dental training opportunities in community based settings. According to the Health Resources and Services Administration (HRSA), physicians trained in health centers are more than three times as likely to work in a health center and more than twice as likely to work in an underserved area as those not trained at health centers. The funding currently available in FY 2015 will not maintain the program's 758 residents at their full per resident amount (PRA) of \$150,000. In addition, the five-year THCGME authorization expires in fiscal year 2015. It is critical that this important program continues and receives adequate funding to support its mission.

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

The College strongly believes that GME financing should be transparent, and accountability is needed to ensure that funds are appropriately designated toward activities related to the educational mission of teaching and training residents.

- Medicare GME funds go directly to teaching hospitals that sponsor training programs, even if the hospitals do not directly incur all of the training costs. Faculty who run training programs often do not know how they are supported, or whether they are receiving adequate support from Medicare. There needs to be greater accountability in ensuring that training programs receive enough funding to develop the most robust training programs and meet the requirements set by their Residency Review Committees.

- In addition, while hospitals are required to provide cost reports annually to CMS, obtaining information on specific direct and indirect payments is difficult. Medicare GME payment information should be made publically available to ensure that these funds are used for the education and training of residents. ACP supports MedPAC's call for an annually published report that clearly identifies each hospital, the direct and indirect medical education payments received, the number of residents and other health professionals that Medicare supports, and Medicare's share of teaching costs incurred. These reports should also include information on progress made in using Medicare GME dollars to meet the nation's workforce goals.

In recent years, some have proposed using a portion of IME dollars to establish a performance based GME payment system in an effort to encourage greater accountability for Medicare's GME dollars and reward education and training that will improve the health care delivery system and/or meet the nation's workforce goals. The College believes that the concept of a performance based GME payment system is worth exploring but cautions that such a system should be thoughtfully developed and considered in a deliberate way to ensure that goals are achieved without destabilizing the system of physician training.

- Members of the academic medicine community are best equipped, by virtue of their medical training and experience as educators, to develop and monitor educational standards. Physicians involved in primary care training should be among the stakeholders consulted in establishing such a system.
- All measures must be carefully developed and thoroughly evaluated before they are implemented and any curriculum-related measures should be linked to the well-established ACGME competencies and competency based educational reforms already underway.
- In addition, a provision must be in place to evaluate the performance-based GME payment system at certain intervals to avoid adverse unintended consequences, ensure that the goals of implementing such a system are achieved, and that the measures are still relevant over time.
- Further, training programs must be allowed adequate time to make necessary changes to their programs before financial incentives are introduced so that they do not risk losing funding at a time when they may need additional resources to meet performance standards.

6. Is the current system of residency slots appropriately meeting the nation's healthcare needs? If not, please describe any problems and potential solutions necessary to solve these problems?

As noted previously, Medicare GME-funding limits on residency training positions have impeded the establishment of new residency programs and additional training positions in existing programs. A thorough assessment of the supply, specialty mix, and distribution of physicians is necessary, and Medicare GME dollars should be used to address any shortcomings.

- This assessment should be a top priority for the National Health care Workforce Commission and the National Center for Health Workforce Analysis.

- While it is imperative that the number and proportion of primary care physicians be increased, the aging of the population will demand a sufficient number of physicians trained in the complex medical problems typical of that age group, including oncology, rheumatology, cardiology, nephrology, geriatrics, pulmonary and critical care, and other internal medicine subspecialties. In addition, other specialties are facing shortages, including general surgery.

It is important to note that a national workforce policy will not be effective in assuring an adequate supply of physicians, and specifically, internal medicine specialists, without changes in reimbursement policies, student debt, and other factors that discourage physicians from going into primary care and encourage those who already are in practice to leave primary care.

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

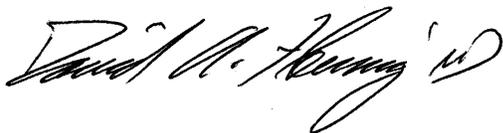
The College believes that both state and federal governments must play a significant role in developing the nation's health care workforce.

Medicaid programs in 42 states and the District of Columbia contribute nearly \$3.9 billion in support for GME, although there is a great deal of variability in the amounts and mechanisms of support. Increasingly, states have played an increasing role in targeting state funds to address state health workforce needs. States have a vested interest in graduate medical education and the College is extremely supportive of these initiatives.

Conclusion

The College shares your concerns about the status of our nation's GME system and believes that GME financing needs to be redesigned to ensure an adequate health care workforce with the skills to care for the needs of society. We appreciate the opportunity to answer these questions and look forward to ongoing discussions with the Committee. Please do not hesitate to contact Renee Butkus, Director, Health Policy at 202-261-4555 or rbutkus@acponline.org if we can be of further assistance.

Sincerely,

A handwritten signature in black ink that reads "David A. Fleming MD". The signature is written in a cursive style with a large, stylized "D" at the beginning.

David A. Fleming, MD, MA, MACP
President