

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 American Society of Plastic Surgeons (ASPS) appreciates the opportunity to respond to the Committee's open letter requesting information on Graduate Medical Education (GME).

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. They perform resections, repairs, replacements, and reconstruction of defects, to ensure the human body functions properly. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer. ASPS promotes the highest quality patient care, professional and ethical standards, and supports education, research, and public service activities of plastic surgeons.

The mission of ASPS is to advance quality care to plastic surgery patients by encouraging high standards of training, ethics, physician practice and research in plastic surgery. The Society is a strong advocate for patient safety and requires its members to operate in accredited surgical facilities that have passed rigorous external review of equipment and staffing.

We are pleased to provide the following responses to the questions posed, and hope our comments will prove useful in clarifying current and future public and private investments in GME.

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

We understand that the distinction between direct and indirect GME funding could no longer be useful. The ASPS believes that all of the current funding is necessary to support physician training and, in fact, should be expanded; however, we agree that academic institutions could be more transparent as to where the funding is used. While there are surely instances of indirect funding being used inappropriately, we believe that the majority of institutions use the money appropriately. ASPS recognizes that, because GME is funded by public dollars, the need for accountability and transparency in any expansion of GME financing will be necessary to meet the needs of the public. To be successful, the undertaking will require data on the true costs and

benefits of residency programs to their sponsoring organizations, as well as a detailed analysis of current funding sources, and an assessment of current and future healthcare workforce needs.

Because a portion of GME funding comes from sources other than the Centers for Medicare and Medicaid Services (CMS), obtaining these data has previously been an impossible task. In hospitals with low Medicare discharges, CMS may not be the only source of GME funding. ASPS encourages the Committee to work with the Department of Defense (DoD), the Department of Veterans Affairs (VA), the National Institutes of Health (NIH), and the Health Resources and Service Administration (HRSA) to better understand their role in GME funding.

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 you support and why?*

Because very few organizations have provided reform proposals in sufficient detail, it is difficult to identify many for which ASPS can provide support. Even the 22nd Report of the Council on Graduate Medical Education (COGME) is quite vague on this very important issue. Of the proposals of which we are aware, we believe that an all payer system could be the most appropriate and promising. The fact that the federal Medicare budget carries the financial burden (with the deficits to be filled by the individual institution) is not sustainable and not sound policy given the broad number of beneficiaries of our medical education system. We realize that GME funding in the future will be challenged and therefore there is a need to find other sources of funding, to include resources from private payers, industry, etc. Along these lines we would encourage the Committee to explore a role for private payers, who currently contribute only a small amount of GME funding, to more actively participate in offsetting the cost of training at teaching hospitals. After all, the care provided by medical students and resident physicians during and after training impacts ALL patients, not just Medicare beneficiaries. Mandating that private insurance companies financially contribute to the medical training of physicians has tremendous upside. A contribution commensurate with their insured population that receives treatment at that academic training program seems reasonable. That said, we do not believe that federal funding for GME should be reduced or eliminated given the public good that derives from graduate medical education. It is an appropriate and important role for the federal government to play.

Reform efforts should supplement, rather than replace existing funding sources. In the last Congressional session, bipartisan legislation such as the Creating Access to Residency Education (CARE) Act of 2014 (H.R. 4282) was introduced that sought to increase funding for designated medical specialty shortages. Multi-faceted approaches, including State-based scholarships and federal matching grants were offered as solutions. Any approach to reform should include flexibility. For example, the Conrad 30-J1 visa waiver program, which allows medical doctors to apply for a waiver for the two-year residence requirement, also allows state agencies some discretion in determining how shortage areas are identified and the types of specialties necessary to fill those needs. New programs should be agile, allowing for changes without significant Congressional oversight.

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 argument of shortage vs. maldistribution of physicians is argued across all medical disciplines. There is increasing evidence that both exist, particularly pertaining to the primary care field, including family medicine, pediatrics, ob/gyn, and general surgery. The majority of Health Professional Shortage Areas (HPSAs) are located in rural America. The lack of physicians in these geographic areas contributes to the rampant health care disparities in these areas, and in an attempt to help ameliorate this, trainees must be exposed to these rural settings. As for the financing implications, if a rural facility can accommodate a trainee then they should also receive some of that institution's IME funding.

A recent American College of Surgeons Health Policy Research Institute study shows an average of two plastic surgeons per 100,000 individuals in the United States. As the population ages, healthcare needs will increase. For example, breast cancer is the second leading cause of death in women. It is estimated that over 230,000 new cases will be identified each year. Several studies have found a direct correlation between the rates of women in a given geographic location who receive breast reconstruction and the number of plastic surgeons practicing in that location. The Women's Health and Cancer Rights Act of 1998 mandates that reconstructive procedures be offered, yet shortages of qualified surgeons have and will continue to limit availability and proper care for the patient.

Plastic surgery shortages are occurring in multiple states, with no recognized geographic pattern in those shortages. Teaching hospitals provide expertise and equipment inaccessible elsewhere. Many patients must travel long distances to receive needed care at hospitals that provide specialized care, including burn trauma and reconstructive services. Incentives to encourage residents to take jobs in underserved areas should be investigated.

Current policy actually incentivizes GME expansion in rural areas, yet few hospitals choose to establish or expand training programs, in part due to complex Medicare regulations governing establishment and operation of rural training tracks. Exploring how best to restructure and expand the reach of established policy will help to optimize outcomes.

For example, programs like the National Health Service Corps (NHSC) should be expanded. This is federal discretionary funding (separate from GME allocations) that offers student loan forgiveness to new physicians willing to work in HPSAs. The early data reveals that a significant proportion of the physicians that participate in the NHSC are staying in these areas even after their obligation has been fulfilled. Making trainees aware of programs like this will be beneficial.

While we concur that training should be required both in rural and urban areas because it offers great exposure to a variety of cases and patient trauma, it is important to note that health needs and demands vary at the local level. Equitable distribution of physicians may not be possible, and attempts to force graduates into targeted areas or specialties would have a limiting effect. Indeed, new policy could inadvertently penalize facilities that are actively addressing specific geographic population needs.

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

a. *Should it account for direct and indirect costs as separate payments?*

ASPS believes that the direct and indirect funding pools could be maintained. These revenue streams are essential for the solvency of large, urban, safety-net institutions that are premier training grounds reliant on GME funding, and in turn provide a significant proportion of indigent care in urban areas where health care needs would not otherwise be met. It is also important to note that current IME and DME funding is calculated on a three-year rolling average rather than a direct correlation to the number of residents being trained in a given year.

i. *If not, how should it be structured? Should a per-resident amount be used that follows the resident and not the institution?*

Residency is a multi-year commitment. Anecdotally, information indicates as many as ten percent of all residents switch specialties each year. Existing Medicare rules include a definition of an “initial residency period,” or the number of years it takes for a resident to become board eligible in the first medical specialty the resident enters.

The Agency can, and often does, reduce funding for a resident who moves from one program to another, depending on the length of the initial residency period. Currently, hospitals with training programs will receive slightly less when a resident is beyond the initial residency period.

The Committee should also be aware that there are complex administrative steps built into the current funding of a residency program. Any changes to that funding structure will reduce a teaching hospital’s ability to maintain the mandated infrastructure.

A plastic surgery residency requires extensive training over a substantial period of time. High case-loads, long work hours, on-call time, and the reality of the administrative burdens on a private practice already impact the number of medical students entering this field of medicine.

Recognizing all of the above, ASPS believes GME funding should be tied to the resident, and not to the institution and that funding needs to remain with the resident through the entirety of their training. For plastic surgery residents, funding should be provided for a minimum of six years.

This change will provide greater flexibility to institutions in soliciting additional funding sources, such as contributions from private payers and industry, should they wish to increase their resident complement. This would help to promote the development of programs in rural areas and ambulatory settings in which health care is most needed. As previously discussed (Question two), encouraging recruitment of additional funding sources for GME besides those provided by the CMS is essential to maintain solvency of the system over time.

ii. *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?*

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

The Affordable Care Act (ACA) calls for resident positions that are regularly not filled at institutions to be reallocated to other institutions that can accommodate additional trainees with a preference expressed for programs that create additional slots in primary care and general surgery. The current financing structure impacts the availability of primary care and specialties. The aforementioned reallocation provision of ACA does simply that, reallocate. This is clearly a shortcoming of the ACA provision as it fails to address the need to expand GME positions. While reallocation might, in theory, help with the physician maldistribution problem, it blatantly ignores the physician shortage problem.

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

Private accreditation and certification entities are already pursuing reforms to GME standards and training methods. As an example, the Next Accreditation System (NAS) and the Clinical Learning Environment Review (CLER) are two programs being offered by the ACGME. NAS requires programs to demonstrate competency in eight domains, including patient care and communication skills. The CLER program focuses on quality and safety during training and into practice. ASPS has invested in the ACGME to ensure that resident trainee is appropriately carried out and they have the capacity to "shut down" or authorize programs. The number of Medicare funded GME positions in the US has remained capped since the Balanced Budget Act of 1997 (BBA). Thus, until Congress increases GME funding the Centers for Medicare and Medicaid Services (CMS) will not have the capacity to reward (through the ACGME) high-quality training programs with additional funded resident positions. If GME funding is expanded and these potential rewards are available then with the assistance of the ACGME they should also have the ability to take positions away from institutions that are not producing high quality physicians. Currently additional positions can be awarded to a high quality institution by the ACGME; however, the burden of funding for that position falls purely on the shoulders of the awarded institution.

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 address these problems?

We believe that the current system of residency slots is antiquated. The anniversary of the cap placed on Medicare funded GME positions is approaching twenty years, and this cap has not kept pace with changes in US health care needs. In 1997, the US population was approximately 270 million. The US population in 2014 was over 320 million. Fifty million additional people and a rapidly retiring cohort of physicians born during the baby boom era have led to a shortage of certain practicing physicians. Maldistribution is undoubtedly a concern, but the absolute shortage of the number of physicians, both primary care and specialists, must be addressed, and it must be done so rapidly.

According to the Association of American Medical Colleges, an overall shortage of 91,000 physicians will occur by 2020. By 2025, the shortfall looms to 130,000. It is also important to note that 83 percent of respondents in a recent ACGME survey say they will reduce the number of residency positions in both primary and specialty care if GME is reduced. Furthermore, a recent survey of Program Directors of Plastic Surgery training programs found that 31 of 51 (62%) programs which responded did not apply to the ACGME for additional residency training spots due to lack of available funding to support additional residents. Residency programs at teaching hospitals have not grown at the same pace as the numbers of consumers entering the healthcare system. Expansions in insurance coverage under the Patient Protection and Affordable Care Act (PPACA), as well as a large number of aging baby boomers in need of health care, have further stressed the system. As such, ASPS believes additional funding will be necessary to ensure that adequate numbers of trained physicians are available to meet the needs of the population. Additionally, federal funding should be used to develop and support programs for physicians, encouraging them to serve as educators, mentors and training program administrators.

Primary care fields undoubtedly will need to be addressed, but the field of plastic and reconstructive surgery has also already documented areas of need. As previously discussed in our response to question two, the passage of the Women Health and Cancer Rights Act of 1998 mandated that insurance providers that covered mastectomy for breast cancer also had to provide coverage for reconstructive procedures pertaining to that mastectomy. As a result there has been a rise in the number of women receiving breast reconstruction; however, not to the extent that was originally anticipated. Several studies have found a direct correlation between the rates in which women in a given location receive breast reconstruction and the number of plastic surgeons practicing in that location. This once again speaks to maldistribution, but an absolute shortage of plastic surgeons is also being identified. In the last 11 years, the number of plastic surgery programs has declined 11 percent. Any additional changes to GME funding will further jeopardize access to services that support resident education.

Recognizing our federal government's fiscal concerns and desire for transparency are necessary but continued investment in the training of our country's physicians must remain a priority. Transparency of how these funds are spent as well as reporting to the federal government regarding the quality of the physician workforce that each program is producing should ensue. In return, programs that have a proven record of producing high quality physicians in disciplines of demand and that go on to practice in areas of need, should be rewarded with additional Medicare-funded GME positions.

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

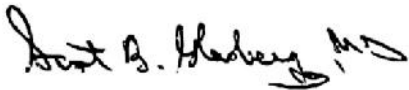
Given the public benefit of medical training, we believe each state should continue to invest in the funding of GME. Since each state administers its Medicaid program, Medicaid could be the mechanism for awarding GME funding. However, given that each state funds and finances state-based programs (and given the financial pressure to which Medicaid programs are constantly subjected), we believe each state should be given the flexibility to determine which GME funding mechanism best meets its needs.

Unfortunately, many states face unique constraints on spending and many have reduced their support for advanced medical training. Others have invested in their own version of the NHSC, providing student loan forgiveness to physicians willing to serve patients in designated shortage areas.

We also believe that each state must continue to study and report their areas and disciplines of physician need to the federal government as well as institutions like the AAMC and ACGME. We believe programs like the NHSC should be expanded and employed by all states to meet their unique needs.

ASPS believes it is essential that our country support the education of physicians to provide care for all citizens. Any changes to the program should meld existing and future funding sources seamlessly. We appreciate the opportunity to offer these comments and look forward to working with the Committee to ensure GME funding remains adequate. Should you have any questions about our comments, please contact Catherine French, ASPS Health Policy Manager, at cfrench@plasticsurgery.org or at (847) 981-5401.

Sincerely,

A handwritten signature in black ink that reads "Scot B. Glasberg, MD". The signature is written in a cursive style with a large initial 'S' and a distinct 'MD' at the end.

Scot B. Glasberg, MD – President, American Society of Plastic Surgeons

cc: Debra J. Johnson, MD – ASPS Board Vice President of Health Policy & Advocacy

Jeffrey E. Janis, MD – ASPS Board Vice President of Education

Arun K. Gosain, MD – ASPS Board Vice President of Academic Affairs and Reconstructive Surgery