January 14, 2015

The Honorable Joseph R. Pitts, Chair
Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington DC, 20515

The Honorable Frank Pallone, Ranking Member
Energy and Commerce Committee
Health Subcommittee
237 Cannon House Office Building
Washington DC, 20515

The Honorable Gene Green
Health Subcommittee
2470 Rayburn House Office Building
Washington DC, 20515

The Honorable Diana DeGette
Health Subcommittee
2368 Rayburn House Office Building
Washington DC, 20515

The Honorable Cathy McMorris Rodgers
Health Subcommittee
203 Cannon House Office Building
Washington DC, 20515

The Honorable Peter Welch
Health Subcommittee
2303 Rayburn House Office Building
Washington DC, 20515

The Honorable H. Morgan Griffith
Health Subcommittee
1108 Longworth House Office Building
Washington DC, 20515

The Honorable Kathy Castor
Health Subcommittee
205 Cannon House Office Building
Washington DC, 20515

Dear Chairman Pitts, Ranking Member Pallone, and Members of the Health Subcommittee,

The American Congress of Obstetricians and Gynecologists, representing 58,000 ob-gyns and partners in women’s health, is deeply appreciative of your commitment to ensuring a graduate medical education financing system that meets our nation’s health care needs. We applaud your leadership in undertaking this important issue and your approach, bipartisan and inclusive, again demonstrates your Committee’s dedication to legislating sound health policy.

We agree with the findings of the Association of American Medical Colleges (AAMC), which show that “by 2020 our nation will face a serious shortage of both primary care and specialist physicians to care for an aging and growing population” and that “there will be 45,000 too few primary care physicians – and a shortage of 46,000 surgeons and medical specialists – in the next decade.”
Our specialty faces current and growing workforce challenges that pose serious barriers to needed care for women across the country.

Workforce shortages are widely predicted over the next 10 years in primary care, a number that will be exacerbated as millions of people gain health insurance under the Affordable Care Act (ACA). Health care coverage is only meaningful if people have timely access to high quality care. Many obstetricians and gynecologists deliver primary care services to women and are often the only physicians many women see. Other ob-gyns focus on surgical and other care, including urogynecology and reproductive endocrinology. Ob-gyns are often the only physicians many women see. In fact, according to the most recently available survey data, almost 6 in 10 women of reproductive age (58 percent) report seeing an ob-gyn on a regular basis and one-third (35 percent) view their ob-gyn provider as their main source of care.

Today, women in many major areas of the country have no access to ob-gyns; 50% of US counties have no ob-gyn. The number of ob-gyns retiring will soon equal the number of ob-gyn resident graduates, amounting to no growth in the number of ob-gyns caring for women. In addition, ACOG projects an ob-gyn shortage of 18% in the US by 2030, while our female population is expected to increase 36% by 2050. This shortage is more troublesome when we consider that 13 million women may gain health insurance under the Affordable Care Act, through Medicaid expansion or in the exchanges. ACOG supports the Medicaid expansion and universal access to care so that all women have access to needed health care, but this promise will mean little if they can’t find an ob-gyn.

Ob-gyn shortages can delay a woman’s ability to receive time-sensitive care, including primary reproductive health care, cervical cancer screening, and prenatal and labor and delivery care. Good prenatal care is critical to helping ensure healthy babies. Over 4 million babies are born every year in the US, one-quarter to mothers who did not receive adequate prenatal care. Babies born to mothers who received no prenatal care are 3 times more likely to be low birth weight and 5 times more likely to die than babies born to mothers who received prenatal care.

GME reform is most certainly needed, and must address these goals:

- Encourage training and educational development of collaborative, integrated team care
- Develop regional systems of care that impart value to our system of graduate medical education by focusing on quality and patient safety, and
- Make certain that ob-gyns are considered as both primary care and specialists in any new program.

Our answers to your questions relate back to these goals.

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

The biggest barrier, by far, to efficiency in GME financing is the current method of distribution of funds. The teaching hospitals receive both direct and indirect GME funds, regardless of whether or not the hospital serves as the Accreditation Council on Graduate Medical Education (ACGME) Sponsoring Institution. ACGME is the independent accrediting organization for residency programs.

ACGME defines a sponsoring institution as “The organization (or entity) that assumes the ultimate financial and academic responsibility for a program of GME. The sponsoring institution has the primary purpose of providing educational programs and/or health care services (e.g., a university, a medical school, a hospital, a school of public health, a health department, a public health agency, an organized health.”

Some teaching hospitals are owned by the ACGME sponsoring institution with a common administration over both the hospital and the teaching programs. However, the majority of teaching hospitals are separate entities from the ACGME sponsoring institutions. In these cases today, hospital administrators receive GME funds and serve as unnecessary middle men between the sponsoring institutions, which have financial responsibility for the residency programs, and the programs themselves. This system erodes the transparency and the flexibility of use of these funds, and drives both the imbalance of specialists/sub-specialists versus primary care and the geographic maldistribution of physicians.

Hospital incentives lead many administrators to favor allocating resident slots to specialties that produce higher cash value billed to Medicare and that most benefit hospital cash flow. This directly contributes to disproportionate training slots for subspecialists as opposed to primary care doctors and limits resident trainees’ opportunities to gain needed experience outside of the teaching hospitals’ systems.

We propose that GME funds should go directly to the ACGME sponsoring institutions of residency training programs as a way of increasing efficiency, stability, and flexibility of GME training.

We specifically urge the Committee to prevent any attempt to subject federal GME financing to the appropriations process, one of the most destabilizing moves that could be made to our Nation’s ability to train physicians.

2. **There are 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?**
ACOG supports HR1201, Training Tomorrow’s Doctors Today, introduced in the 113th Congress by Reps. Schock and Schwartz which would enhance transparency and allow the training environment to adapt as demographics, delivery models, and health care needs change.

ACOG supports HR 4385, the Improving Access to Maternity Care Act, introduced in the 113th Congress by Committee Members Rep. Burgess, MD and Rep. Capps. This legislation would create a maternity care shortage area designation in the National Health Service Corps (NHSC) and allow data collection on shortage areas based on provider type and geographic region. We urge the Committee to support this bill when introduced in the 114th Congress.

The NHSC was created in 1972 to help fill health provider shortages in federally designated underserved Health Professional Shortage Areas (HPSAs); more than 45,000 providers have participated in the program. Currently there are over 9,000 NHSC providers serving 9.3 million Americans across the US.

The program provides scholarships and loan repayments in exchange for service in a NHSC site. The scholarship program provides tuition assistance and a living stipend in exchange for 2-4 years of service, and can be awarded for up to 4 years. The loan repayment program provides up to $50,000 in loan repayment in exchange for at least 2 years of service.

There are shortage area designations for primary care, dental care, and mental health, but not for maternity care. Currently, maternity care providers are distributed to primary care sites that don’t take into account the maternity care needs of underserved communities. HRSA does not collect information about important aspects of maternity care, including the availability of hospitals with labor and delivery facilities, or the level of care they are able to provide, such as NICUs.

The ACA provides a total of $1.5 billion in new, dedicated funding for the NHSC over five years, FY2011 to FY2015, funds that are in addition to annually appropriated discretionary funds. We urge the Committee to continue this funding past FY2015, as well as the NHSC’s State Loan Repayment Program. These programs provide scholarships and loan repayment to health professionals, including ob-gyns, in exchange for practicing primary care in federally designated HPSAs.

ACOG supports an all-payer system of financing graduate medical education. Government, all hospitals, medical liability companies, medical group practices, and insurers benefit from our graduate medical education system and all should contribute to underwriting this needed effort. Combined funds, which would go directly to a new GME Trust Fund, would be paid out to sponsoring institutions on a per-resident basis. Funding should pay for 12 months per year of an individual’s training, regardless of the various sites at which that person trains during the year. Today’s GME financing mechanism limits primary care training, since direct GME funds are reduced when residents are on off-site rotations not affiliated with the teaching hospital. These sites are where much primary care exposure can take place.
Residency programs should be encouraged to rotate residents to the best educational opportunities. Sponsoring institutions should have the unrestricted flexibility to rotate residents beyond the teaching hospital. An all-payer system that provides a yearly per-resident amount will increase training opportunities, and expand resident exposure to a greater variety of geographic and primary care settings.

All-payer funding has been recommended many times over many years. The 15th Report of COGME, the Council on Graduate Medical Education, summarized a number of these proposals. We offer elements of COGME’s summary, below, as potentially helpful historical background to the Committee’s work.

**PEW HEALTH PROFESSIONS COMMISSION**

The PEW Commission (1998) recommended an all-payer financing mechanism exclusively dedicated to supporting entities involved in the clinical education of physicians, advanced practice nurses, and physician assistants. All entities providing clinical education, including consortia and children’s hospitals, would be eligible for payment.

There would be a uniform per resident amount for direct GME costs that would vary only for external reasons such as geographic differences in the cost of living.

Eligibility for IME payments would be consistent with those for direct GME payments. IME payments would be distributed among teaching hospitals, affiliated academic institutions, and non-hospital training sites.

The Commission proposed expanding the National Health Service Corps’ loan repayment program and allowing specialists to participate where needed.

**THE COMMONWEALTH FUND**

The Commonwealth Fund’s Taskforce on Academic Health Centers (1997) recommended leveling the playing field for academic health centers and other teaching hospitals by establishing explicit all-payer financing for their social missions. Payments for direct GME costs would be made on a per resident basis.

**1997 CONSENSUS STATEMENT ON THE PHYSICIAN WORKFORCE**

The AMA and other major GME stakeholder associations issued a consensus statement in 1997 on GME financing and workforce issues, which supported an all-payer fund for direct GME costs. Funds would flow to entities that incur the costs of GME, hospital-based or not, or to consortia that have been designated to receive funds on behalf of the entities that incur the costs.
3. Should federal funding for GME programs ensure training opportunities are available in rural and urban areas? If so, what sorts of reforms are needed?

Quality experiences in ambulatory settings require a strong and interested faculty, a patient base that is clinically diverse, and a site that integrates training and trainees into the daily operation of the practice. The key is to ensure adequate funding for training for all sites that meet ACGME standards, not to have an equal number of rural and urban training sites.

Residency programs require an adequate supply of clinical variety and patient volume to give residents satisfactory practice experience. Training sites in smaller communities can be suitable for ob-gyn and other primary care providers and provide direct exposure to areas of need where they might later choose to practice. But often, the training opportunities afforded to residents at these sites would need to be augmented by more robust opportunities at larger facilities.

A financing system, as we describe above, that encourages sponsoring institutions to rotate residents to the best training opportunities can help increase the number of residents working in rural settings.

Rather than developing legislative solutions, we urge the Committee to continue to rely on ACGME and the Residency Review Committees to determine the appropriate number of slots for each specialty, and to determine whether residency programs meet the standard value thresholds. We urge you to maintain ACGME’s authority to ensure quality education and to continue working with the certifying boards and medical specialty societies.

4. Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?
   i. Should it account for direct and indirect costs as separate payments?
      a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?
      b. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsible to current and future workforce needs?
   ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

The current system of indirect payments (disproportionate funding, upper payment limit funding, etc.) to teaching hospitals has historically been justified by the excess cost burden of uninsured patients. Along with the anticipated decrease in the uninsured population as a result of the Affordable Care Act, the ACA reduces DSH funds from FY2014 through FY 2020.
A per-resident all-payer system, while not necessarily increasing the actual number of slots, will allow more efficient use of current slots to meet the needs of our population. This system would open the doors to training opportunities in rural areas and likely increase the number of residents who would choose primary care careers in those areas. The current financing structure impacts the distribution of specialty and primary care designations. Hospitals don’t receive GME payments when residents are off-site, so hospital administrators are more likely to designate GME funds for on-site non-primary care specialty rotations and training. A per resident funding system would help break this barrier to primary care and community site training.

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

All residency programs receiving GME funding are already vetted by the ACGME to meet the highest quality standards. ACGME provides oversight and accreditation, in coordination with the certifying boards and medical specialty organizations. ACGME accreditation measures programs to determine the fulfillment of educational requirements, to assess the quality and safety of patient care, to promote interprofessional team care, to insure continuous quality improvement, and to maximize use of health information technology.

A reformed GME financing system that relies on per resident reimbursement plus ACGME oversight will inherently increase quality as inefficiencies and outmoded requirements are left behind.

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.

The current system, by inadvertent design, trains a disproportionate number of subspecialists, compared to the needed number of primary care ob-gyns and other physicians. The root of this imbalance goes back to the antiquated concept of the teaching hospital having resident physicians as “house staff.” This has evolved into a bias of residency slot allocation based on service value to the hospital as manifested in high in-patient volume and cash benefit to the hospital.

A reformed GME system, as we propose above, would result in reallocation of existing slots and encourage the development of interprofessional training with physicians and non-physician providers. Interprofessional teams can increase the patient care reach of our existing physician workforce and lead to improve patient access and satisfaction.
Our Nation’s health care system is moving toward integrated care, but GME training has not kept pace to reflect this change. By reallocating existing slots and developing interprofessional training, we may also increase the number of slots available to primary care physicians.

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

States must be integral partners in reforming GME, ideally as part of an all-payer system. Many GME sponsoring institutions are state universities and entities. States also have a significant financial stake in GME through Medicaid contributions. States should continue to participate in providing financial support for GME.

Thank you very much for initiating this important conversation and for inviting ACOG to participate. Generations of Americans, and the future of our nation’s health and health care system, stand to benefit from the thoughtful leadership you are bringing to this issue. The American Congress of Obstetricians and Gynecologists looks forward to working closely with you and your staff toward a better graduate medical education financing system.

For further discussion, please don’t hesitate to contact me or Lucia DiVenere, ACOG’s Officer of Government and Political Affairs, ldivenere@acog.org, at any time.

Sincerely,

John C. Jennings, MD, FACOG
President