WISCONSIN HOSPITAL ASSOCIATION, INC.

January 15, 2015

The Honorable Joseph Pitts, Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

The Honorable Frank Pallone Jr., Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

RE: OPEN LETTER REQUESTING INFORMATION ON GRADUATE MEDICAL EDUCATION

Chairman Pitts and Ranking Member Pallone:

On behalf of over 130 hospitals in the state of Wisconsin, the Wisconsin Hospital Association (WHA) appreciates the opportunity to provide your committee with our perspectives on Graduate Medical Education and ongoing collaborative work in our state on this issue.

Several years ago WHA analyzed our state's future physician capacity needs. That research was included in our Physician Workforce Report: "100 Physicians a Year, *An Imperative for Wisconsin.*" The report documented that Wisconsin faces a shortage of physicians over the next 20 years, and that action must be taken to meet the challenge. Their analysis found Wisconsin would see a shortfall of 2,000 physicians by 2030—translating into the need for an additional 100 new physicians per year to keep pace with demand. [To read WHA's complete report, please log onto at: http://www.wha.org/Data/Sites/1/pubarchive/reports/2011physicianreport.pdf .] Many of these physicians will be needed in primary care and in rural or underserved communities.

The purpose of this seminal report was not to simply highlight the looming physician shortage, but to begin working proactively as a state to meet this need. Since that time WHA and other stakeholders have worked aggressively and collaboratively on changes. We are seeing results. Examples of this effort include the Wisconsin Council on Medical Education and Workforce, which focuses on having more students graduate from Wisconsin medical schools, and the WHA Task Force on Graduate Medical Education, working to increase the number of post-graduate

medical education positions in Wisconsin. Other examples include creative new education and training models like the Medical College of Wisconsin's (MCW), based in Milwaukee, which created the MCW Community Medical Education Program. This program includes the creation of two new MCW campuses in northern Wisconsin communities. In addition, WHA has worked with our Governor and State Legislature to help secure millions of dollars in funding through our state budget for MCW as well as help fund new residency programs. Finally, Wisconsin hospitals and health systems themselves have invested $176 million in 2013 alone to train health professions.

We are committed to proactively trying to meet our state's physician and health professions capacity needs, but cannot do so without continued federal GME funding. With this background in mind and your Committee's request for comment on the current Medicare GME funding mechanism, please accept the following information and four WHA recommendations as you deliberate.

Graduate Medical Education – Key Facts, Statistics

- AAMC estimates a shortage of up to 45,000 primary physicians by 2020 and 130,000 overall by 2025.
- The Wisconsin Hospital Association, in a 2011 study, projected a shortage of over 2,000 physicians in Wisconsin by 2030, a shortage that will be felt largely in rural and underserved areas of the state.
- Medicare has effectively frozen its level of GME support since 1997, which means nearly 10,000 physician training positions have been added since then *without* Medicare support, paid for entirely by sponsoring health systems.
- In general, direct graduate medical education (DGME) payments are based on 1983 training cost estimates.
- Children's hospitals, one percent of all hospitals nationally, train nearly 50 percent of all pediatricians and pediatric specialists.
- Wisconsin stakeholders – our hospitals/health systems, medical schools, the University, state government – are working collaboratively to meet our State's workforce and patient care needs. Congress plays a vital role in our success by continuing strong support for Graduate Medical Education.

Graduate Medical Education - Background

Graduate Medical Education (GME) is the hands-on training phase of physician education that is mandatory in order for doctors to obtain a license for independent practice. After four years of college, physicians-in-training complete another four years of undergraduate medical education (medical school) to earn their M.D. degrees, and then proceed to GME (or residency) training.

This training varies in length but generally lasts three to five years for initial specialty training; those in subspecialties may train for up to 11 years more after medical school. This training is supported by teaching hospitals, though the clinical experience occurs in a variety of settings. These residency opportunities help to train the next generation of physicians through essential clinical experiences.

Due to the importance of training this next generation of physicians, the Medicare program has been committed to paying its share of the costs for the education of the country's residents**.** When Congress created the Medicare program in 1965, it established a Medicare GME funding stream to support the training of the nation's medical residents to provide care to Medicare beneficiaries. There are two types of Medicare GME payments: direct graduate medical education and indirect medical education.

These Medicare GME/IME payments are based, in part, on the number of residents a hospital trains and the number of Medicare patients it treats. Direct costs have been capped since the 1997 Balanced Budget Act by limiting payments based on the number of residents each teaching hospital had in its program in 1996.

DGME Payments
DGME payments are based on a formula that includes a hospital's Medicare percentage of total inpatient days, total number of residents, and a per-resident amount (PRA)

IME Payments
IME payments are calculated as a percentage add-on payment to a hospital's base DRG rate for all patient-care activities.

Because children's hospitals see very few Medicare patients, a separately funded federal program known as the **Children's Graduate Medical Education (CHGME)** provides freestanding children's hospitals with federal graduate medical education support to train pediatricians similar to the funding that other teaching hospitals receive through Medicare. The CHGME program was authorized in 1999 and is funded differently than adult Medicare GME program, in that Congress must continually authorize and appropriate funds to the CHGME program. Only freestanding children's hospitals that have their own Medicare provider number are eligible to receive CHGME funding. However, it is important to note that children's hospitals across the country train roughly 50% of the pediatricians and pediatric specialists in the United States and that when discussing GME overall, these programs must not be left behind.

WHA Recommendation 1: ***Maintain GME Funding, Increase Coordination/Transparency Through Single Federal Entity***

WHA urges Congress to continue to recognize the importance of Graduate Medical Education funding. Reductions in GME funding will result in the loss of residencies at the very same time our nation's physician capacity needs are expanding.

According to the U.S. Census Bureau, the U.S. population is projected to increase by 8 percent in the next 10 years, with the Medicare population increasing by about one-third. An adequate physician workforce must be available to treat this expanded population. Estimates by the AAMC nationally show the need for 130,000 more physicians by 2025 and the **WHA estimates that for Wisconsin, 2,000 more physicians will be necessary to meet our state's needs. A significant portion of physician capacity need is**

WHA Recommendations

Recommendation 1: ***Maintain GME Funding/Increase Transparency, Coordination***

Recommendation 2: ***Provide Greater GME Program Flexibility to the States***

Recommendation* 3:** ***Provide additional dollars for innovative GME models

Recommendation 4: ***Prepare Medical School Curriculum Graduates, Residents for Future***

expected to be in the primary care field. Further, 83 percent of Wisconsin's counties are designated as fully or partially underserved. For rural Wisconsin, this is even more acute when a full 77% of those underserved counties are rural.

According to the AAMC, the costs of training a resident averages $100,000 or more per year. Medicare's share of that cost is usually around $40,000. In addition, Medicare has effectively frozen its level of GME support since the Balanced Budget Act of 1997, which means nearly 10,000 training positions in the United States have been added since then *without* Medicare support. As a result, teaching hospitals bear the bulk of these physician residency costs. While the Medicare GME program provides *vital* funding for teaching hospitals, the real cost of providing residency training services – which benefit communities and the health and well-being of patients – is far higher. These GME costs have only increased over time while Medicare's support has been effectively capped since 1997.

Reductions to the federal GME program would impact all types of hospitals and all types of communities seeking to train residents. For example, teaching hospitals rely on physicians-in-training to help care for patients at less cost than attending physicians. Rural sites, already facing shortages, find narrow "rural training" definitions and GME financing difficult. For pediatric hospitals, cuts to CHGME would seriously damage the ability to train pediatricians. Altering or reducing GME payments would harm Wisconsin's ability to train future physicians, especially when, as a state, we are planning and working proactively to ensure we have an adequate physician workforce.

We are encouraged that the Institute on Medicine's report recommends maintaining current GME funding, but believe its recommendation for redistributing those funds is not a viable option due to the complexity and disruptive impact that would have across our state and the nation. That being said, WHA has been a strong proponent of health care transparency initiatives – see our PricePoint (hospital pricing, http://www.wipricepoint.org/) and CheckPoint (hospital quality, http://wicheckpoint.org/Home_main.aspx) websites as examples **– and do support the need for those receiving GME funds to be accountable for appropriate use and for effectiveness in meeting program policy goals.**

This transparency and accountability could be achieved through the following:

- Creation of a single federal agency accountable for GME. This entity could enhance policy development at the national level while minimizing inconsistencies and inefficiencies in administration. The current structure includes multiple agencies yet none with overall accountability.

- Provide more transparency on the entire GME program structure and impact. Program operations and funding are often based off of arcane, decades-old policies, making it difficult to understand and hard to assess GME program effectiveness. Since there is an interrelationship between funding and how residency programs operate, it will be valuable to have more transparency of how the program is structured and operates in order to make the most effective policy decisions going forward.

- ❖ Establish appropriate reporting requirements that allow for assessing policy objectives and program effectiveness. This also helps provide the supporting data that will be necessary for making future program policy recommendations and improvements.

WHA Recommendation 2: *Greater Program Flexibility to the States*

Nationally, GME caps were set in 1996 and continue to hamper the ability to start up new residency programs or expand current ones. At present, WHA estimates Wisconsin has 30.7 medical residents per 100,000 population. This is below the United States average of 35.7 and well below other Midwestern states such as Michigan and Minnesota, 46 and 42.4 per 100,000 population respectively.

WHA believes Medicare's 1996 caps, which locked in place each hospital's situation at a point-in-time, are outdated and must provide additional flexibility in order to meet our future capacity needs. Ideally, Medicare caps on residency training positions should be lifted in areas, like Wisconsin, where new medical school campuses are being developed. However, states should have the necessary flexibility to most appropriately meet their own capacity needs.

For example, in a number of states like Wisconsin, medical schools are opening new campuses in areas where the need for physicians is greatest. The **Medical College of Wisconsin (MCW) is one such example of an expansion.** The MCW's initiative is to develop a community medical education program that both addresses the need for providers in underserved communities across Wisconsin and employs an immersive teaching model that will reduce student debt and allow students quicker entry into practice. However, the success of programs like MCW's will depend on an adequate number of residency training sites. MCW's expansion is great news for Wisconsin because history shows that where physicians are trained is a good predictor of where they will practice.

Example of Need for Flexibility in GME Caps: MCW Expansion

Several hospitals in the regions where the Medical College of Wisconsin (MCW) is starting new campuses have had previous experience as training sites, but only for a handful of residents. As a result, their resident FTE caps are much lower than the anticipated number of medical school students that will be graduating from MCW's two new campuses, projected at 25 per site. Resident programs in these regions will need to be large enough to accommodate the graduates, or they risk losing those graduates to other residency programs. This would defeat the purpose of educating and training students in one place in order to maximize the chances of retaining them.

In fact, the WHA's report, "100 Physicians a Year, *An Imperative for Wisconsin*" documented that some 86 percent of physicians who attended medical school in Wisconsin and completed their residency here stayed in Wisconsin. New graduate medical education positions need to be in place so that these medical school graduates will have a place to continue their training, but outdated residency cap requirements can hamper the development of such programs. That is why WHA believes the Medicare program needs to

provide flexibility in those cases where a hospital has a very low cap but now wants to become involved in an expanded program.

Further, additional attention and flexibility should be provided to the specific issues faced in rural and underserved areas. Geographically dispersed and often separated from their sponsoring program or academic medical center, rural training tracks (RTTs) have unique difficulties that should be recognized. For example, there may be more volatility in the numbers of slots an RTT can handle from year to year. This works against an RTT because currently, in order to get redistributed GME slots, an RTT would have to show it filled all slots for the prior several years, and would have to give the slots back if it didn't fill them going forward. Again, flexibility in redistribution of caps could help in this regard.

Wisconsin: Examples of Proactive Work In Progress

Medical College of Wisconsin – creating new medical school campuses in Green Bay area and Central Wisconsin communities to address physician shortages and meet patient needs throughout Wisconsin.

Medical College of Wisconsin – Urban and Community Health – medical education pathway linked with community needs and assets to prepare medical students to effectively care for patients in urban communities, promote community health, and reduce health disparities.

UWSMPH's Wisconsin Academy for Rural Medical (WARM) – has expanded the UWSMPH class size by selecting in-state candidates who demonstrate appreciation, commitment to practicing in rural and underserved WI communities and provide their clinical education in regional and rural sites throughout Wisconsin.

UWSMPH's Training in Urban Medicine & Public Health (TRIUMPH) – combines certain existing Milwaukee-based rotations, fourth-year preceptorship and electives with community/public health experiences.

For example, if Congress wanted to specifically target its efforts at priority situations, WHA would suggest lifting Medicare's cap on residency training positions for situations like those in Wisconsin where new medical school campuses are being developed.

WHA Recommendation 3: ***Provide Additional Dollars To States For Innovative GME Models***

States are incubators of invention and WHA believes Congress could create a separate innovation fund, using new dollars, to encourage new GME models. One way to do so would be to block grant additional dollars to states for GME models that meet specific needs. For example, Congress could established key criteria to base these GME programs on, such as percent of rural or underserved populations or ratio of population to primary care physicians.

As our second recommendation points out, state flexibility is important. In this case, states could take these block granted dollars and make funds available to those health care organizations that are creating or innovating in GME. The state would then be held accountable for appropriate use of the funds and report back to the newly created federal entity overseeing GME programs.

If you would like to understand how this could work in a state like Wisconsin, through our multi-stakeholder effort, we were able to work jointly with the Governor and legislature to develop

several funding mechanisms for GME. Those mechanism included a grant-making process that provided incentives for either expanding existing programs or creating new programs. Those programs needed to be able to demonstrate they were creating residencies in key area, like family medicine, general internal medicine or psychiatry, for example. Additionally, the programs also needed to ensure residents have significant exposure to rural or underserved populations in Wisconsin.

All total the program was authorized in our current biennial budget and allowed some $1.75 million per year to be used to develop new programs, and $750,000 annually to expand existing accredited GME programs. During 2014, over $7 million was awarded to ten hospitals and health systems. Over the next five years, more than sixty new residency positions will be created in family medicine, psychiatry, and general surgery. Grantees will be required to report their progress on a regular basis.

These are great results for a state like ours and are an example of the agility we have to more quickly respond to our state's specific needs. This is again where the federal GME program can be a key partner with the states.

WHA Recommendation 4: ***Ensure Medical School Curriculum Prepares Graduates, Residents for Future***

Significant healthcare transformation is taking place as we speak, including the potential for millions more individuals to come into coverage, an aggressive movement towards medical homes and team-based care, increased roles for advanced practice professionals, a strong movement towards health care integration and value-based care to name a few. Practicing medicine in the future will look different than it does now, and it will be important that our medical schools and residency programs prepare future physicians adequately to practice and thrive in that future.

In that vein, health systems in Wisconsin and nationwide have begun to move toward team-based care delivery. Whether referred to as the medical home or other models, the team-based approach appears to hold promise as a way to more efficiently deliver care. But we need to better understand what these delivery systems are likely to look like and understand their impact on the health care workforce. WHA recommends the following options to help medical school curriculum and residency training be able to prepare future physicians for this transition:

- Incorporate team-based care delivery models into the medical education curriculum and provide clinical situations where physicians and other health professionals can practice in team settings.

- Additional study on the future medical care delivery system. There is a need to better understand how medical care is likely to be delivered in the future. The results of this study could be used as reference for developing medical school curriculum and in identifying the demand for non-physician providers.

- Increase the number of non-physician providers being trained. Based on projected need as determined from further study, increase the number of non-physician providers trained.

- ❖ Establish an infrastructure and a vehicle for the dissemination of best practices regarding team-based medical delivery.

As delivery of medical care moves towards team-based and value-based care, a coherent national GME program and approach helps ensure physicians have the necessary clinical training experiences.

Again, thank for this opportunity to submit comments to the Committee on Energy & Commerce regarding the future of Graduate Medical Education programs. If you have any questions, please contact Jennifer Boese, VP-Federal Affairs & Advocacy, at 608-268-1816 or jboese@wha.org. We stand ready to assist you in your efforts.

Sincerely,

Eric Borgerding, President & CEO
Wisconsin Hospital Association