The Society of Thoracic Surgeons

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January 15, 2015

The Honorable Fred Upton
United States House of Representatives
Chairman, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
United States House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Representative Pallone:

On behalf of The Society of Thoracic Surgeons (STS), the largest organization representing cardiothoracic surgeons in the United States and the world, I appreciate the opportunity to provide comments regarding graduate medical education (GME). While imperfect, GME financing has supported robust medical education and training that is emulated by many other nations and produces the highest-quality physicians. Our nation's public health and economy are linked to the effectiveness and availability of a capable and strong physician workforce.

According to the Association of American Medical Colleges (AAMC) Center for Workforce Studies, there will be a shortage of over 100,000 physicians, including 62,000 surgeons and medical specialists, over the next decade. A progressive decrease in the number of physicians will affect everyone, but the vulnerable and underserved populations will experience the most severe impact. Approximately 20 percent of Americans reside in rural or inner-city locations that are designated as health professional shortage areas by the Health Resources and Services Administration (HRSA).

Lawmakers have recognized that GME must have secure and predictable funding, and such a precedent is why Medicare has historically played a fundamental role in financing GME. Federal support has become even more critical as surgical care undergoes sweeping changes to modernize and develop new payment and delivery models. We therefore echo a key recommendation in the Institute of Medicine's (IOM) recent GME report, "Graduate Medical Education That Meets the Nation's Health Needs", which supports Medicare GME funding at current levels and suggests modernizing

payment methods by which the program rewards performance and incentivizes innovation.[1]

One of our primary concerns is the prevalence of proposals that seek to reduce funding for GME. We believe that decreasing payments to this key public resource would harm patients and exacerbate existing barriers to care. In summary, we believe that the following improvements would help to secure a more stable and effective physician workforce:

- Raise the cap on Medicare-supported residency positions;
- Increase the number of GME positions to address future physician workforce, regional, and specialty needs; and
- Work to prevent the permanent loss of unused thoracic surgery training positions to primary care or other specialties.

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

STS believes that the cap on publicly funded GME training slots should be raised. Medicare must continue to provide for training costs by supporting at least a 15 percent increase in GME positions, which would allow teaching hospitals to prepare another 4,000 physicians a year to meet the needs of an aging population.

GME financing must also reflect the changing health care environment. AAMC predicts a deficit of approximately 65,800 primary care and 64,800 specialists is expected by 2025.[2]

Cardiovascular disease accounts for more than one-third of the deaths in the United States, and the Medicare-age population most frequently affected by cardiovascular disease is expected to double by 2030. America's cardiothoracic surgeons are also aging, more than half of the current workforce is 55 years and older. [3] According to a recent HRSA report, cardiothoracic surgery is expected to lose 24 percent of its workforce over the next decade.[4]

A scarcity of cardiothoracic surgeons could have dire consequences for Medicare beneficiaries. Ensuring an adequate workforce of skilled surgical specialists, through sensible and sustained GME financing, will be crucial to population health.

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[1] Graduate Medical Education That Meets the Nation's Health Needs. Available at http://www.iom.edu/Reports/2014/Graduate-Medical-Education-That-Meets-the-Nations-Health-Needs.aspx

[2] Physician Shortages to Worsen Without Increases in Residency Training. Available at https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

[3] Shortage of Cardiothoracic Surgeons is Likely by 2020. Available at http://circ.ahajournals.org/content/120/6/488.abstract

[4] Projecting the Supply of Non-Primary Care Specialty and Subspecialty Clinicians: 2010-2025. Available at http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/clinicalspecialties/clinicalspecialties.pdf

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?

STS has supported GME legislation that addresses the changing needs of patients and our health care system. The Resident Physician Shortage Reduction Act of 2013 (H.R. 1180/S. 577), bi-cameral legislation that would create 15,000 additional GME positions by 2019, was a step in the right direction. We believe similar legislation would begin to mitigate the impending physician shortage and would ensure patient access to appropriate care.

While STS did not agree with all aspects of the IOM report, we were encouraged by some of its proposals. In particular, we agree that the residency cap must be lifted, overall GME funding should not be reduced, and innovative payment reforms should be tested and evaluated.

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?

STS supports further investigation of geographical and economic factors that lead to vacant cardiothoracic residency positions in rural and urban areas. In addition, STS supports loan forgiveness programs that would encourage physicians to train and practice in underserved areas, as well as programs that would encourage training in medical and surgical specialties with projected workforce shortages.

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

STS supports maintaining adequate and stable Medicare GME funding, and cautions that imposing future limits could have an adverse effect on patients and the physician workforce. We therefore agree with the IOM and others who have concluded that Medicare support for GME should not be reduced.

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

STS supports expanded options and benefits for enhancing integrated six-year cardiothoracic surgery training pathways where residents are selected out of medical school. Currently, the average eight years of training for cardiothoracic surgery after medical school includes five years or more of general surgery training and two to three years of cardiothoracic training—which can dissuade medical students from pursuing the specialty. There are currently 17 integrated cardiothoracic residency programs in the U.S., which offer a thoroughly relevant curriculum while decreasing the total length of training.

In addition, STS supports the Accreditation Council for Graduate Medical Education as the appropriate body for oversight and enforcement of resident work hours. STS recommends against additional federal oversight or regulation of resident work.

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?

As described previously, STS is concerned about our nation's health care system which is facing a rising physician shortage, and that enough qualified medical school graduates are neither entering programs in some of the most complex specialties nor practicing in underserved regions. The declining fill rate of cardiothoracic residency positions is problematic for a patient population that requires increasingly more valve procedures, lobectomies, and other open heart procedures.

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

STS acknowledges that many states have implemented programs that mirror the federal approach to address the challenges of rural recruitment and retention. It is our hope that states will continue to develop and invest in initiatives that reward and incentivize the practice of medicine in their most vulnerable communities.

Conclusion

STS remains committed to supporting GME so that our nation can educate the future physician workforce and promote residency training that provides them with the skills to meet the nation's health care needs. Given the critical importance of GME funding, we hope that the Committee focuses on ways to enhance the quality of medical training while ensuring access to care for patients is preserved. Should you have any questions regarding this letter, please contact Courtney Yohe, STS Director of Government Relations, at (202) 787-1222 or cyohe@sts.org.

Sincerely,

David A. Fullerton

David A. Fullerton, MD
President