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

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

January 16, 2015

Dear Chairman Upton and Ranking Member Pallone:

The American Academy of Pediatrics (AAP) is an organization of 62,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. As such, we are highly invested in ensuring that there is a current and future well-trained pediatrician workforce to meet the needs of our country’s most vulnerable population, our children.

We believe that GME training is a public good that is essential to the production of pediatricians who practice the highest quality patient-centered care and increase the availability of health care for all children and their families, including the underserved and those with special health care needs. No institution other than the federal government is positioned to adequately invest in this public good, and as such, it is vitally important to continue federal investments in GME.

We appreciate your “Open Letter Requesting Information on Graduate Medical Education” and believe it is an important step in addressing the many, complex, proposals that have been advanced pertaining to reforming GME funding programs. Having carefully considered your questions from both the GME and pediatrician workforce perspectives, we submit the following information for your consideration.

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

In order to improve the stability of the current GME financing system, the AAP recommends that a stable source of funding be provided for the Children’s Hospital Graduate Medical Education (CHGME) program at a similar level as GME programs that are sponsored by other teaching hospitals and related institutions and funded through the Medicare program. The CHGME program supports the training of approximately half of all pediatric trainees in the United States at over 50 freestanding children’s hospitals. Because freestanding children’s hospitals receive
little or no GME funding from Medicare, their GME programs are very dependent upon CHGME funding to operate their training programs. Unfortunately, unlike Medicare GME funding, Congress must appropriate funds annually for the CHGME program and each year established training programs are unsure if sufficient funds will be available to continue their programs. Since the duration of pediatric GME training is 3-6 years for each trainee, trainees in these children's hospitals could potentially lose their positions if adequate funds are not appropriated. This lack of stable funding is also a disincentive for children's hospitals to maintain or expand current training programs. Creating stable funding could help reduce the current shortage of pediatric medical subspecialists and pediatric surgical specialists in the United States. The need for stable CHGME funding was also noted in the IOM report on financing GME, which supported a stable and equitable source of funding for pediatric residents in free-standing children’s hospitals.

To improve the effectiveness of the current GME financing program, the AAP recommends that GME funding be preferentially provided to programs that are training residents in primary care and the specialties that are currently experiencing shortages such as pediatric medical subspecialties and pediatric surgical specialties. The goal of GME funding should be to produce an adequate and competent physician workforce with the appropriate specialty mix. This goal cannot be met unless changes are made in how Medicare GME funding is allocated because the current Medicare guidelines allow training programs to utilize their GME funding for any accredited program, regardless of the physician workforce needs in their community.

The effectiveness of GME programs in addressing workforce shortages also could be improved if the practice location of GME program graduates was monitored and incentives were provided for GME programs that increase the number of graduating trainees who enter practice in underserved communities, including rural areas. The types of activities that residents/fellows engage in that are eligible for GME funding should allow trainees to receive training in a variety of appropriate settings; funding should be directed to these settings to offset the costs of training residents. In addition, GME funding should be directed to the institution that pays trainees’ salaries and benefits, not limited to activities that take place at the sponsoring institution alone.

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?**

The AAP supports proposals that call for an increase in the current public funding of GME. We also support expanding the sources of funding to include all sectors of the health care industry who gain from a well-trained pediatrician workforce including hospitals, health care systems, health maintenance organizations, the pharmaceutical industry, private and public insurers, medical device and equipment companies, health information technology and others. The AAP also supports the recommendation from the Council on Graduate Medical Education to increase the number of fully funded residency training positions in pediatric surgical specialties, child psychiatry, pediatric medical subspecialties, and general pediatrics (a pipeline to further pediatric

medical subspecialty and surgical specialty training), as this would improve access to care and enhance pediatric health.

The AAP also supports proposals that call for the allocation of both the public and private GME funding in a transparent manner in order to ensure that the funds are being used appropriately for GME training and proposals that recommend that funds be distributed in a manner that addresses the United States’ current and future pediatrician workforce needs.

Further, the AAP supports promoting innovation in GME. However, the AAP does not support the process proposed by the IOM report that would take away a portion of existing GME funding to develop innovation incentives through an additional bureaucracy.

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 AAP believes that it is important to ensure that training opportunities are available in both rural and urban areas. To accomplish this, the following areas of reform are needed to ensure these training opportunities are available at diverse sites that are not part of the sponsoring institution:

Current GME funding formulas discourage sending residents away from the sponsoring institution. Specifically, when a resident completes some training off-site, the sponsoring institution does not include those hours within the calculations to determine Centers for Medicare and Medicaid Services (CMS) or CHGME funding. However, the sponsoring institution typically remains responsible for paying that resident’s salary and fringe benefits costs as well as covering medical liability insurance costs. This results in a significant financial loss to the sponsoring institution. Financing would need to be reformed to allow sponsoring institutions to still be paid their cost for managing residents who train outside the sponsoring institution to help offset these costs, which include medical liability insurance, and the ongoing duties of the residency and GME offices of the institution that provide the educational structure and assessment activities for other training sites. There should also be clear mechanisms to provide ongoing GME funding to the rural sites that are based on the training activities that have been agreed upon between the rural site and the sponsoring institution.

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

The current financing structure for GME is not appropriate to meet current and future healthcare workforce needs. The AAP supports a financing structure that is transparent, equitable and addresses current and future workforce needs. The AAP also supports a GME funding structure that fully funds training for all pediatric physician trainees, including pediatric medical subspecialists and pediatric surgical specialists, for the full length of training required to meet the standards of each of these pediatric and pediatric medical subspecialty and pediatric surgical specialty programs. A financing structure that follows the resident for the full length of their
American Academy of Pediatrics
Page 4

training could potentially create greater transparency and more equitable distribution of the GME funding to the site of training. Currently, Medicare GME funding is distributed to teaching hospitals using a formula that is based in part on inpatient hospital days for Medicare patients and number of residents assigned to the hospital setting. This approach creates a disincentive for training programs to utilize ambulatory care sites for training and incentivizes training in hospital settings as well as training programs that are hospital-based.

Restructuring should account for both the sponsoring institution’s role in providing benefits (health insurance, medical liability insurance, payroll management expenses, employment expenses, individual residency program office expenses, etc.) and expenses incurred at the site of training; the former should be completely attributed to sponsoring institution while the latter portion should go to the training site even if that site is not the sponsoring institution. The sponsoring institution should cover the costs for global health training experiences due to the overhead involved in arranging for such experiences.

The current financing structure does not influence or impact the choices of trainees regarding primary care versus specialty selection processes. Federal funds should be used responsibly to address the health care needs of its citizens, including promoting a strong primary care workforce and a robust, innovative pediatric medical subspecialty and surgical specialty workforce. Any change to the financing structure should promote both and should take into account differing needs of different specialties (e.g. internal medicine may have too many subspecialists while pediatrics has a major shortage of subspecialists in almost all areas); and should allow flexibility for state level priorities to meet the needs of local citizens.

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

The quality of training programs in the United States are already rigorously regulated by the Accreditation Council for Graduate Medical Education (ACGME). Specific requirements for training programs are developed by the ACGME Residency Review Committee (RRC) for each specialty. Federal GME requirements should not replace the important role ACGME already plays in ensuring quality medical education. While better metrics are always possible, they should continue to be coordinated by the ACGME and RRCs.

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?**

While it is critical to maintain the number of primary care pediatric residency positions, there is currently an inadequate number of training positions for pediatric medical subspecialists and pediatric surgical specialists to meet the needs of the nation’s children. In addition, the current redistribution process of unused positions is too cumbersome and too infrequent for training programs to make timely adjustments to respond to patient care and workforce needs. The AAP
supports increasing the number of funded training positions overall and especially those for pediatric medical specialty and pediatric surgical specialty training. This funding should be targeted to the subspecialties experiencing the greatest shortages and should incentivize subspecialty practices that provide care for children who are currently underserved by subspecialists, including children living in poverty as well as those living in small and rural communities.

First, there needs to be a discipline-specific focus on workforce needs with prioritization of those areas most likely to provide the most good to patient well-being. Once these needs are identified, there should be some discipline-specific prioritization in the slot allocation process to best address specific specialty shortages. As an example, internal medicine and pediatrics both have a need for primary care providers. However, unlike internal medicine, pediatrics also has a growing shortage of medical subspecialists and surgical specialists. The pediatric medical subspecialty and surgical specialty shortage is exacerbated by the inadequate number of trainee positions currently available to address these shortages in light of the impending retirement of the aging pediatrician medical subspecialty and surgical specialty workforce. The differences in these disciplines should be taken into account in slot allocation instead of combining the specialty workforces that care for children with those that primarily care for adults, as appears to have been the process of the IOM Committee’s recent work on GME. In addition, because workforce shortages may change over time, there should be an established process for monitoring healthcare workforce needs using data that reflects the current adequacy of the workforce in all disciplines, especially those that are considered essential to the U.S. health care delivery system. The results of this ongoing monitoring should be used to inform periodic adjustments in slot allocations to dynamically keep up with changing needs.

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

Although most workforce forecasting is done at the national—or sometimes regional—level, the AAP maintains that there is an important role for states to play in defining our healthcare workforce needs. States, on the frontline of health reform implementation and transformation, should be encouraged and supported with adequate federal resources to engage in useful data collection that can be utilized to guide strategies for future health care delivery with a well-trained, diverse, and geographically distributed workforce.

The value of state, local, or granular data collection to healthcare workforce planning needs cannot be underestimated. A uniform data analysis process—that is free from bias or agenda—that all states implemented using a standard nomenclature, survey design, and data collection and reporting method would be invaluable. Several organizations have advocated for this approach and the AAP supports it.

Together with the federal government and the medical community, states are key stakeholders in this national issue. Their engagement in healthcare workforce planning can ultimately improve graduate medical education and physician training, retention, distribution, and diversity.
The AAP is an enthusiastic and dedicated participant in the deliberations pertaining to the funding and reform of GME. The AAP believes that the current financing structure for GME is not adequate to meet the current and future healthcare workforce needs. We support reforms that call for a transparent and equitable GME funding structure. Additionally, the AAP has long advocated for a stable source of funding for CHGME as an important mechanism for reducing the current and future shortage of pediatric medical subspecialists and pediatric surgical specialists in the country. We also urge that GME funding be preferentially provided to programs that will train residents in primary care and the specialties that are currently in shortage, such as pediatric medical subspecialties and pediatric surgical specialties. The AAP believes that any consideration of reforms aimed at improving the training of physicians, accountability and quality should begin with a focus on the quality of health for all patients. The AAP looks forward to continuing this important dialogue and will gladly provide additional information.

Sincerely,

Sandra G. Hassink, MD, FAAP
President

SGH/jdb