



January 16, 2015

Congressman Joseph R. Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Congressman Gene Green
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Re: Open Letter from Members of Congress Requesting Information on GME

Dear Chairman Pitts and Ranking Member Green:

The American Geriatrics Society (AGS) appreciates this opportunity to comment on your request for feedback on the U.S. Graduate Medical Education (GME) program. Our organization has long believed that GME can play an important role in building the healthcare workforce we need to ensure high-quality patient-centered care for our nation's seniors.

AGS is a national non-profit organization comprised of over 6,000 health professionals, including physicians, nurses, researchers, medical educators, pharmacists, physician assistants, social workers, health care administrators, and others who specialize in the care of the elderly. Our members are responsible for furnishing and directing care for our nation's growing number of older adults with multiple and complex conditions. However, we have a burgeoning elderly population and an inadequate geriatrics healthcare workforce. In the next two decades the number of Americans who are 65 and older – and eligible for Medicare – will nearly double. The nation's aging baby boomers will be unlike the generations of older adults before them. They are expected to live longer than their predecessors and to have more chronic and complex health conditions. According to CMS, as of 2010, 68 percent of Medicare enrollees suffered from two or more chronic conditions. Of particular concern, these enrollees accounted for 93 percent of Medicare spending.

We strongly believe that a reformed GME system is essential to building a future healthcare workforce with the skills and training to meet the unique and complex care needs of the growing number of Medicare beneficiaries. Care tailored to these patients' needs – the kind of coordinated care that geriatrics healthcare professionals provide – **could improve outcomes and cost-effectiveness**. We firmly believe that improvements in quality or efficiency of care will not be fully realized without a concomitant commitment to ensuring that GME training programs are preparing the healthcare workforce to meet the unique challenges of an aging population. Several organizations have recognized these problems and how they relate to graduate medical education:

- GME must be accountable and effective (Macy Conference Proceedings, 2011).
- The entire healthcare workforce needs to be competent to care for older adults (IOM, 2008).
- Institutions using Medicare dollars to support GME should be providing training to enable health professionals to develop competency in the care of older adults (MedPAC, 2010).
- A geriatrics competent workforce will contribute to higher quality, safer and more cost effective care for patients (IOM, 2008).

We support changes to the GME program that would:

- Increase the number of geriatricians and other primary care physicians, and enhance the geriatrics knowledge and expertise of practicing surgeons and medical specialties providing care to older adults.
- Promote interdisciplinary care through team-based training of physicians and other healthcare professionals including advance practice nurses and physician assistants.
- Require that all approved medical residency programs (aside from Children's Hospitals) include geriatrics competency/curriculum requirements.
- Provide additional flexibility to allow training in other care settings beyond hospitals.
- Enhance fiscal transparency and accountability.
- Provide a mechanism for periodic adjustment of funding allocations and residency positions based on current and projected healthcare needs.
- Increase the cap on GME-funded residency slots. Determination of the number and allocation of new residency slots must be closely aligned with identified workforce needs.

Below we have addressed the questions put forth in your open letter dated December 6, 2014.

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

To address the care needs of Medicare beneficiaries, especially those with complex and chronic conditions, it is imperative that sufficient federal resources be dedicated to increasing the number of physicians, including geriatricians, and other health professionals with the knowledge and skills to meet the unique care needs of older adults. Since funding for the GME program comes from Medicare, American taxpayers and beneficiaries should reasonably expect that the available resources are appropriately aligned to improve the care of older adults and, concurrently, address our nation's growing shortage of geriatrics healthcare providers.

A new performance-based GME financing system that includes geriatrics curricula requirements and increased accountability will help to ensure that resources from the Medicare program are used appropriately to enhance the training of all physicians who care for older adults. Training should include understanding the complexities involved in the care of the frail elderly, their physiology, and collaboration with fellow members of the interdisciplinary geriatrics healthcare team.

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?

AGS has supported a number of proposals in the 113th Congress that would serve as an important first step in building a healthcare workforce trained to care for the rapidly growing population of older Americans.

[Training Tomorrow's Doctors Today Act \(HR 1201\)](#)

This legislation, introduced by Representatives Schock (R-IL) and Schwartz (D-PA) and also endorsed by AGS, tackles workforce issues by increasing the number of Medicare-supported residency positions and addressing transparency and accountability within GME. In addition to increasing the number of slots by 15,000, this legislation includes several other important components including a study and report identifying physician shortage specialties, a study addressing the competency of the workforce to care for older adults and an annual report detailing all Medicare GME payments made to hospitals.

Better Care, Lower Cost Act (S 1932/HR 3890)

This legislation, introduced by Senator Wyden (D-OR) and Representative Paulsen (R-MN), provides a framework that aims to address the needs of Medicare beneficiaries with multiple chronic conditions by creating an integrated chronic care delivery program that promotes accountability and better care management for chronically ill patient populations. AGS specifically supports a provision that establishes new curricula requirements for direct and indirect graduate medical education payments. These new requirements address the need for team-based care and chronic care management, including palliative medicine, leadership and team-based skills and planning, and leveraging technology as a care tool.

Community-Based Medical Education Act (S 2728)

This legislation, introduced by Senator Patty Murray (D-WA) and endorsed by AGS, aims to strengthen our nation's graduate medical education system and ensure continued access to primary care and geriatrics. The bill includes several important components aimed at increasing the primary care workforce including a new primary care teaching program that will fund 1,500 new residency spots, including geriatrics. This legislation also extends the expiring Teaching Health Centers program through 2019 – training approximately 550 medical residents each year in rural and underserved communities. Beginning in 2019, the legislation would replace the program with a permanent, mandatory funding stream under Medicare that emphasizes training in primary care and geriatrics.

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?

Yes. GME funding should allow for more flexibility in the sites where residents train. Currently, teaching hospitals are often located in large, urban areas resulting in minimal training being done in rural settings where 62 million Americans rely on rural health providers. Of note, rural areas of the U.S. have fewer than half as many primary care physicians per 100,000 people as urban areas of the U.S. Rural patients often have to travel long distances to reach a physician, which can be especially challenging for older adults who often have more medical appointments and difficulty traveling compared to younger persons. It's therefore not surprising that rural Americans are more likely to be older, poorer and sicker than their urban counterparts.

Programs created under the Affordable Care Act, including Teaching Health Centers (THCs) and Rural Training Track (RTT) programs, encourage medical students to receive primary care training in these community-based settings and underserved communities. These programs have shown that physicians often decide to practice in the rural and underserved communities where they are trained. A recent study of RTT graduate outcomes found that at least half RTT graduates were located in rural areas after graduation, two to three times the proportion of family medicine residency graduates overall.

Federal funding should also support cross-institutional collaborations such as an effort being led by Dr. Kevin Foley in Michigan that has created a network of geriatrics fellowship programs that provides opportunities for programs to work together on evaluating the competence of geriatrics fellows to care for older adults. These types of networks are particularly important in rural areas where young physicians will often want to remain in the community where they intend to settle while pursuing advanced training.¹

¹ Foley, Kevin. Neuberger, M. Noel, M. Sleight, D. vanSchagen, J. Wadland, W. Advancing geriatrics fellowship program through a community-based residency network, *Fam Med*, PMID: 24347189, December 2013, Volume 45, Issue 10, PP 719-25.

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 responsive 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?

No. As stated above, we have a burgeoning elderly population and an inadequate geriatrics healthcare workforce, as the IOM recognized in its 2008 report, *Retooling for an Aging America*. There are currently about 7,000 certified geriatricians in the U.S., and AGS estimates that we will need about 25,000 by the 2025. Furthermore, over the past decade, the healthcare landscape has dramatically changed. Shortages of healthcare providers in primary care, including those with geriatrics training, have grown even more acute. In addition, with previously uninsured patients now covered under the Affordable Care Act, more and more demands are being placed on our nation's primary care workforce.

There are federal programs and policies outside of Medicare that are central to the training of the primary care physician workforce and to geriatrics. AGS works in partnership with HRSA and other stakeholders to advance the education and training of the eldercare workforce under Title VII and Title VIII geriatrics programs. These programs have, and continue to make a difference in preparing the healthcare workforce to care for our aging population. There is a critical need to enhance and dedicate more resources to these programs, and AGS and other eldercare organizations that are part of the Eldercare Workforce Alliance, are working with policymakers on these priorities.

Concurrently, however, more needs to be done on a much broader scale to ensure that future physicians – in primary care, geriatrics and across specialties – are prepared to care for an unprecedented number of older adults. A reformed GME program – funded by Medicare and our nation's core program for training physicians – is the appropriate federal program for this purpose.

As a first step to reforming the payment system, ***direct and indirect payment should be replaced with one payment that is based on a national per-resident amount (PRA)*** (with a geographic adjustment), as stated in the 2014 IOM report on Graduate Medical Education. The payment should also follow the resident – meaning that the funding stream should be distributed directly to venue of care in which the resident is training. Unfortunately, under the current payment methodology framework, there is a significant counterincentive to move residents out of hospitals and train in other facilities where patients receive care. When patients train offsite in community health centers or office-based practices, GME funding is shifted away from hospitals. Furthermore, the current system does not make it easy for other sites to obtain the GME funds via the hospital, narrowing opportunities for residents to train in non-hospital settings. The financing structure also affects the mix of specialty and primary care designations. Under today's system, there are huge incentives to provide specialty care and not primary care or geriatrics. Hospitals make their money by providing high-end services, such as bone marrow transplants and interventional radiology. Similar to training offsite, there are counterincentives to training primary care physicians and geriatricians.

AGS recommends that ***geriatric medicine be explicitly recognized as a primary care discipline within the GME system*** to create consistency across federal statutes. Geriatricians are principally primary

care providers for the most complex and frail older adults. In its 2008 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that geriatricians utilize a higher rate of primary care billing codes than other specialties. Geriatric medicine is also explicitly included by statute as an eligible primary care specialty under the Primary Care Incentive Program. Recognizing geriatric medicine as primary care in the GME program will add consistency and signal that geriatric medicine fellowship slots should be protected in any reallocation of slots by institutions. Currently, primary care is often defined as internal medicine, family medicine, osteopathic medicine, and pediatrics.

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 current system does not incentivize high-quality training programs. To elaborate on the discussion above, older Americans' interactions with the health care system often involve providers across the health care spectrum and in many different settings. These interactions include providers in emergency departments, a specialist's office, a skilled nursing facility, and hospital. The care of older persons in these sites must take into account the unique needs of older individuals. The GME training of these providers should integrate geriatrics principles into the curriculum to increase the number of healthcare workers who practice the principles of geriatrics as they care for older Americans. **Currently, however, Medicare's GME financing does not place any requirements on geriatric skills and experience.**

Several organizations have underscored the need for GME to include training in geriatrics:

- The Medicare Payment Advisory Commission stated in its 2010 Report to Congress: “An educational goal that is particularly pertinent to Medicare is the growing need to basic geriatric competency among almost all our physicians,” and that GME should be accountable for delivering that goal.
- The Josiah Macy Foundation Conference Proceedings in 2011 on Ensuring an Effective Physician Workforce for the United States declared, “Physicians require new skills to care for an aging patient population with increasingly complexity.”

Many reports have also cited the growing population of older adults as the primary reason for reforming the GME system. Reports from COGME, the IOM, and a number of primary care and specialty organizations have made this point. AGS believes that any reform of the system must pay attention to not just the numbers of physicians trained but also to the content of that training. AGS has participated in efforts to define the core competencies that all physicians should have² as well as in specialty-specific efforts including emergency medicine and surgery.^{3,4} AGS led an effort to define the core competencies that family and internal medicine residents should possess at the end of residency.⁵

AGS strongly recommends that GME financing system be changed to include performance based payments tied to standards, including geriatrics competency requirements. The level of GME funding to the institution should, at least in part, be performance-based, with funding contingent upon the institutional performance with specified educational standards and outcomes. Practice-based geriatrics learning requirements should be one of these standards. Geriatrics curricula requirements

² Minimum Geriatric Competencies for Medical Students (June 2010)
<http://www.americangeriatrics.org/files/documents/Minimum.Geriatric.Competencies.063011.pdf>

³ Minimum Geriatric Competencies for Emergency Medicine Residents (March 2010)
<http://www.americangeriatrics.org/files/documents/GEM.Competency.Chart.and.Description.pdf>

⁴ Proposed Competencies in Geriatric Patient Care for Use in Assessment for Initial and Continued Board Certification of Surgical Specialists (August 2011) <http://www.americangeriatrics.org/files/documents/JACS.Competencies.pdf>

⁵ Minimum Geriatric Competencies for IM-FM Residents <http://www.americangeriatrics.org/files/documents/Min.Ger.Comp.pdf>

are needed to ensure that resources from the Medicare program are used appropriately to enhance the training of physicians in geriatric medicine, including understanding the complexities involved in the care of the frail elderly, care coordination and working in interdisciplinary geriatrics health care teams.

Geriatrics is known for its interprofessional team approach to care. A geriatrician will often work together with others including, but not limited to, a nurse, psychologist, social worker, nutritionist, physical therapist, occupational therapist, consultant pharmacist and/or geropsychiatrist to compose a geriatrics team. Each team member plays an important role in the proper assessment and care of an older patient and their unique care needs. The AGS-led Partnership for Health in Aging has developed a set of geriatrics competencies that entry-level professionals in a number of fields should possess upon entering practice. This list of competencies covers the essential skills that all healthcare professionals should have, however, they are intentionally broad in order to be easily integrated into each disciplines' training and certification requirements.

<http://www.americangeriatrics.org/files/documents/pha/PHAMultidiscComps.pdf>

Increase flexibility for training in ambulatory settings

More flexibility should be allowed for ambulatory settings to provide training opportunities for geriatricians, primary care providers and other specialties. The Teaching Centers Program, as discussed above, should be reauthorized and expanded to provide more training opportunities in community-based settings. We have identified a small but growing number of mid-career clinicians who are interested in becoming certified in geriatrics. The barrier is often the way in which Fellowship training is structured. Congress should consider how best to incentivize mid-career physicians to undertake additional training in geriatric medicine. One solution might be to create a funding mechanism that would financially support those with this interest by replacing lost income as they complete the clinical requirements of fellowship training.

Innovative Geriatrics Training Programs

The GME program should foster innovative approaches to provide geriatrics training and evaluate competency-based outcomes of its trainees. Residency programs that emphasize geriatrics training are already showing positive results in changing the culture of institutional residency training.

One example of a successful innovative training approach is the Chief Resident Immersion Training program (CRIT, funded by the Donald W. Reynolds and John A. Hartford Foundation). It has been conducted at 16 institutions nationwide. It has been extremely successful at implementing collaborative geriatrics care across disciplines and increasing chief residents' teaching and leadership skills. This program fosters collaboration among disciplines in the management of complex older patients by bringing chief residents and faculty members together for an intensive two and a half day retreat. The CRIT program focuses on chief residents because of the key roles that they play in the quality of patient care, medical student and resident training, mediating concerns across disciplines, and communicating with patients and families.

AGS has also worked to improve specialty physicians' competence in geriatrics through its Geriatrics for Specialists Initiative (GSI). Through GSI and support from the John A. Hartford Foundation, AGS offers a number of Geriatrics Education for Specialty Residents (GSR) Toolkits, which are designed to increase education for residents in the geriatrics aspects of their disciplines. These toolkits have been refined by teams of specialty clinician-educators and their colleagues in geriatrics to ensure that they are consistent with how faculty in their discipline might look for materials to use in training. They are currently available for resident training programs in anesthesiology, emergency medicine, general surgery, gynecology-urology, ophthalmology, orthopedic surgery, otolaryngology, and physical medicine/rehabilitation. Since 2001, the GSR has made 82 awards for specialty-specific initiatives

focused on providing physicians with the skills that they need to care for older adults, who have different needs than the general population.

Additionally, in the past several years, the Center for Medicare and Medicaid Innovation has placed an explicit focus on workforce preparedness in its call for proposals under the Innovations Challenge.

Federal Investment in Geriatrics and Gerontology Faculty

There should also be a *significant federal investment in the development of faculty to provide training in geriatrics and gerontology. Specifically, the Title VII and VIII Geriatrics Workforce Enhancement Program (GWEP) under the Health Resources and Services Administration (HRSA), provides an opportunity to train and incorporate geriatrics and gerontology faculty.* Expanding funding to the GWEPs – especially those that explicitly train faculty – could help to prepare the geriatrics workforce of the future. These are the only federal programs that increase the number of faculty with geriatrics expertise – and do so for a variety of disciplines who provide training in clinical geriatrics, including the training of interdisciplinary teams of health professionals. Increased funding can result in better care for older adults and supports for family caregivers. Additionally, performance-based standards under a reformed GME program could be structured to encourage recruitment and training of faculty in geriatrics and gerontology.

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 is not working. Medical schools, particularly those with strong primary care programs, are facing a shortage of primary care residency slots. Medical school enrollment continues to grow because of the push for schools to increase enrollment and the opening of new schools nationwide. If the number of GME slots is not increased by lifting the cap, and allocating a sufficient number to primary care and geriatric medicine, there will be no measurable impact on reducing the shortages in primary care and geriatrics. Instead, there will be increased competition for U.S. graduates and fewer slots.

The Institute of Medicine has identified the need to make further investments in geriatrics if we are to increase the number of physicians electing to pursue additional fellowship training in this discipline. Further, the Council on Graduate Medical Education (COGME) recommended that geriatric medicine receive increased GME funding should Congress take action on reform of the GME system.

Geriatrics Fellowship Programs

Geriatrics Fellowship programs play an essential role in training physicians to specialize in the care of older adults. Geriatricians are physicians trained in internal medicine or family practice who choose to pursue a year of additional specialized training in the care of older adults.

Geriatrics is facing a significant shortage of physicians entering the field, in large part due to new physicians opting for training in specialties that are more lucrative. The payment system, based on payments for procedures, also provides a disincentive for hospitals to make geriatrics residency positions a priority. As a result, geriatrics fellowship positions at some academic medical centers are not always filled.

To address this issue, we recommend that the GME program and other federal policies provide incentives to encourage, or even require, entities receiving GME funding to recruit and retain physicians pursuing specialized training in geriatrics through a geriatrics fellowship program and/or through other appropriate education and training programs. One option is for the GME program to

apportion a higher level of funding to pay for geriatrics residency positions, as well as for other specialties experiencing shortages.

Additionally, AGS believes that there are potential incentives for increasing the number of young physicians choosing geriatrics as a career. These include loan repayment programs specifically targeted to geriatrics health professionals, allowing geriatric medicine GME slots to be used for a 2nd year of training in order to enhance the faculty pipeline by providing enough time for young physicians to acquire the research and teaching skills they will need to be successful in their academic careers.

The National Health Care Workforce Commission

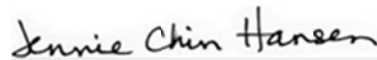
In order to ensure that GME resources are properly aligned with the nation’s healthcare needs, GME funding must be utilized to support ongoing research and analysis to identify these needs, including the current demand for primary care and specialists, and to develop a strategy. The Affordable Care Act (ACA) included the establishment of the National Health Care Workforce Commission to conduct this type of research; however Congress has not provided the necessary funding for it to be convened. Of note, a 2010 MedPAC report recommended that the Commission conduct work analysis to determine the number of residency positions needed in the United States in total and by specialty. This analysis would examine and consider the optimal level and mix of other health professionals. The report also suggested that the Commission study strategies for increasing the diversity of our health professional workforce and report on what strategies are most effective to achieve this pipeline goal. AGS believes that the Commission’s work is a necessary first step to align GME policy with the pressing requirements of the nation’s health care system.

Thank you for considering our comments. If you would like to discuss this matter further, please don’t hesitate to contact Alanna Goldstein at agoldstein@americangeriatrics.org or 212-308-1414.

Sincerely,



Wayne C. McCormick, MD, MPH, AGSF
President



Jennie Chin Hansen, RN, MS, FAAN
Chief Executive Officer