

January 16, 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 American Society of Nephrology (ASN), thank you for the opportunity to provide comments on the Graduate Medical Education (GME) financing program, including its governance and structure and potential opportunities to improve the program.

ASN is the world's leading organization of kidney health and science professionals, representing more than 15,000 physicians, scientists, nurses, pharmacists, physician assistants, and other health professionals who improve the lives of patients with kidney disease every day. ASN and the professionals it represents are committed to providing outstanding experiences for trainees who care for those with kidney disease now and in the future.

Recognizing that a robust GME program is essential to ensure patient access to care, ASN appreciates the Committee's interest in improving the sustainability and efficiency of GME training. More than 20 million Americans have kidney disease and are at risk for progressing to kidney failure, and nearly 500,000 Americans whose kidneys have failed rely on lifesaving dialysis. Kidney disease care is unique in that every American with kidney failure is eligible for Medicare coverage under the Medicare End-Stage Renal Disease (ESRD) Program, regardless of age or income.

Significant health disparities exist for patients with kidney disease who are among the most vulnerable and costly populations; the cost of care for a patient with kidney failure accounts for a disproportionately large share of the Medicare budget. Ensuring a sufficient supply of optimally-trained nephrologists to care for the unique population affected by kidney disease—as well as researchers and clinicians scientists to advance new kidney cures—is crucial to reducing the economic and societal burden of kidney disease. Efforts to improve and stabilize the GME program are fundamental to this goal.

ASN applauds the Committee's interest in improving the effectiveness and sustainability of the training of the next generation of clinicians. ASN is similarly committed to fostering a skilled, efficient workforce to care for the millions of Americans with kidney disease, including efforts to

increase interest in nephrology as a career, mentor and educate trainees, and promote innovation in kidney therapies.

Reflecting ASN's commitment to provision of the highest quality of training to result in optimal use of federal funds, ASN submits the following comments regarding GME financing. In summary, ASN recommends:

- Recognizing that given the unique care needs of the costly, vulnerable population of patients with kidney disease, training the next generation of nephrologists is essential to achieve the highest quality, highest value patient outcomes.
- Affirming that the GME program must ensure not only well-trained subspecialists to care for complex chronically ill but also a supply of clinician-scientists and researchers to develop the therapies and care delivery systems of the future.
- Defending funding for training beyond initial certification.
- Supporting an “all-payer” model for GME funding to ensure stability of funding in the future.

As noted above, kidney care is distinct from other areas of medicine for several reasons. People with kidney disease are a particularly vulnerable, chronically ill population; half of the patients who begin dialysis die within three years, and almost none are well enough to maintain employment while on dialysis. Health disparities are present at every level of kidney disease; for instance, underrepresented minorities are between two and four times as likely to progress to kidney failure, and a disproportionate share of people with kidney disease live in rural or inner-city areas. Underrepresented minorities and socioeconomically disadvantaged people with kidney failure are significantly less likely to be wait-listed for the best therapeutic option: a kidney transplant.

Meanwhile, the demand for care related to kidney disease and kidney injury is increasing. All indications—including an aging population, increased life expectancy, and an increasing incidence and prevalence of kidney disease and injury—indicate the need for nephrology services is likely to continue increasing.

The burden of kidney disease is economic as well as social: The Medicare ESRD Program provides coverage to every American who has progressed to kidney failure regardless of age or disability. Currently, people with kidney failure constitute less than 1% of the Medicare patient population yet the cost of their care accounts for approximately 7% of Medicare costs—a total of nearly \$35 billion annually. Beyond the ESRD Program, Medicare expenditures for patients with chronic kidney disease exceeded \$45 billion in 2011.

The societal and economic burden of kidney disease underscores the imperative need for an adequate, highly-trained workforce for patients with kidney disease. A robust GME program to train the next generation of nephrologists is essential to achieve the best kidney patient experience of care at reasonable cost.

A preponderance of patients with kidney disease have multiple other serious chronic co-morbidities, including diabetes, peripheral vascular and cardiovascular disorders requiring coordinated, highly specialized care. According to the Centers for Medicare and Medicaid Services, more than 51% of patients with kidney disease have 5 or more co-morbid conditions, and more than 83% have 3 or more co-morbid conditions. Nephrologists are specifically trained to manage these multiple co-morbidities, develop appropriate care plans, and coordinate

treatment for these patients. Effective management of these co-morbidities is especially important for patients with earlier stages of kidney disease, during which proper care from a nephrologist can help slow the progression of kidney disease towards kidney failure as well as prevent the advancement of costly co-morbidities that are caused or worsened by kidney disease, such as hypertension.

Troublingly, interest in nephrology has dropped precipitously, potentially compromising the pipeline of caregivers, educators, researchers, and innovators in kidney care. The percentage and number of U.S. medical graduates selecting nephrology has been steadily decreasing for 12 years, and more recently international medical graduates' interest has waned. Consequently, many nephrology fellowship programs failed to fill through the 2014 National Residency Match Program (NRMP); just 0.8 applicants applied for every available nephrology fellowship position. This decrease in the number and percentage of medical graduates selecting nephrology fellowship training has heightened concerns about the ability of the specialty to attract the most highly qualified physicians that will be needed to care and innovate for this vulnerable patient population.

Responding to these concerns, ASN founded a Workforce Committee dedicated to implementing strategies to increase interest in nephrology careers, including supporting innovation within medical education. In recognition of the growing role of technology in education and training, the Workforce Committee recently announced the "2015 ASN Innovations in Kidney Education Contest," to develop innovative tools to teach medical students and residents aspects of kidney physiology, including how it relates to human health, disease diagnosis, or a disease state. ASN also offers several educational and mentoring programs with the mission of attracting the brightest minds to nephrology and helping them succeed. Kidney TREKS (Tutored Research and Education for Kidney Scholars) is a weeklong summer course to introduce medical students and PhD candidates to nephrology. In the Kidney MAPS (Mentor and Assessment Program for Students) program, trainees help raise public awareness about kidney disease by conducting kidney health screenings at locations across the country. The society has also partnered with experts at George Washington University to produce a series of investigative reports regarding the state of the nephrology workforce and future care needs. ASN would be pleased to provide a copy of these reports if it would be helpful.

Although the reasons for declining interest in nephrology as a career are multifaceted, the fact that there are relatively few innovative new therapies to treat or prevent kidney disease is an important contributing factor. Recently, the Committee's 21st Century Cures Initiative highlighted the need for improvements in the therapeutic pipeline, and nowhere is this need greater than in the field of nephrology. Scientific advances have translated into tangible breakthroughs in other areas of medicine, yet research and development in the area of kidney disease has been relatively stagnant. The field of nephrology has generated the fewest randomized controlled trials of any internal medicine subspecialty, contributing to a therapeutic gap for drugs that treat the kidney. In lieu of effective new tools to help patients or a track record of exciting research successes, concern exists that the brightest minds entering medicine and research will bypass the kidney space—further compromising likelihood of novel, cost-efficient therapies for people with kidney disease.

Responding to these concerns, ASN founded a public-private partnership with the U.S. Food and Drug Administration (FDA)—the Kidney Health Initiative—dedicated to fostering innovation in kidney care in 2012. The mission of this public-private partnership is to advance scientific understanding of the kidney health and patient safety implications of new and existing medical products and to foster development of therapies for diseases that affect the kidney by creating a

collaborative environment in which FDA and the greater nephrology community can interact to optimize evaluation of drugs, devices, biologics, and food products. To date, KHI has nearly 70 patient, health professional, pharmaceutical, device, and dialysis company members and is making significant progress to eliminate barriers to innovation in several aspects of kidney care.

But the therapeutic advancements of the future are predicated in large part on the existence of a skilled workforce: The GME program must ensure not only well-trained subspecialists to care for complex chronically ill but also a supply of clinician-scientists and researchers to develop the therapies and care delivery systems of the future, including in nephrology. Notably, specialists make up the vast majority of clinical investigators (MD-PhDs). These considerations highlight the vital importance of continuing to provide GME funding beyond the initial certification.

Nephrology can only advance the objectives of the 21st Century Cures initiative by reinvigorating interest in the specialty and inspiring the next generation of researchers; ensuring a stable, efficient GME program is fundamental to this goal.

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

The availability of a stable GME funding source is critical for maintaining and even growing the nephrology workforce. The incidence and prevalence of chronic kidney disease continues to increase. With the expected rise in the incidence of diabetes, the leading cause of kidney disease, projections are for even further increases in the future. Because chronic kidney disease is more common in patients of lower socioeconomic status who already have more limited access to medical care, any decrease in the number of nephrologists will have a disproportional impact on these more vulnerable patients.

In anticipation of cuts in GME funding, teaching hospitals and sponsoring institutions are spending considerable time and resources on contingency planning to determine which training programs should be cut. These discussions are influencing trainees' decision-making as they contemplate career options. These efforts also take up valuable time and resources that could be better spent on training-related issues.

ASN strongly supports stabilization of GME funding and believes that any efforts to reform GME financing should supplement, rather than replace, current funding sources. The society also supports an "all-payer" model for GME funding to ensure stability of funding. This could also provide an opportunity to develop and assess alternative formulas for funding that are based on metrics other than total inpatient days Medicare patients spend in the hospital. This is especially important in nephrology as we try to have more care, and consequently training, done in the outpatient and home setting.

ASN also strongly supports equal funding of training for initial board certification and secondary certification in specialties such as nephrology. Currently GME funding is reduced by 50% for secondary specialization. This funding model does not reflect the value nephrologists add to the healthcare system considering that they are most often the principal physicians for their chronically ill patients with kidney diseases and numerous other co-morbidities. As noted earlier, the pipeline of physician-scientists is overwhelmingly filled by trainees pursuing specialty disciplines such as nephrology making preserving secondary certification GME funding crucial for research and innovation. Therefore, the structure of the current GME financing system

compromises both access to specialists as well as the clinician-scientist pipeline for researching kidney disease and other costly conditions.

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 that you support and why?

ASN observes that the current GME funding program has made possible many successful aspects of the current nephrology training system, and the society would encourage maintaining stable GME funding to support these efforts. For example, the American Council of Graduate Medical Education (ACGME) recently enacted a competency-based (rather than time-based) system wherein trainees work towards achieving specific milestones that mark their increasing ability to provide high-quality care and positive patient outcomes. Implementation of the Next Accreditation System requires greater resources in an environment where additional expenditures have not been available, and ASN believes that financial resources to support these training experiences must be maintained to provide a high quality workforce for the vulnerable population of kidney patients. Notably, the American Board of Internal Medicine's Maintenance of Certification (MOC) program is also increasingly focusing on lifelong learning and ongoing physician participation in quality improvement activities.

The unique ESRD Medicare bundled payment system and Quality Incentive Program provides significant value, generating accountability and savings that Medicare tracks closely. Institutions must be able to provide the education needed to attract and educate learners who are capable and prepared to provide the highest-quality care in this cost-conscious environment; putting training dollars at risk could undermine this critical element of education. In nephrology, this must include educational experiences regarding multispecialty teams, the cost and value of diagnostic and treatment options, delivery of patient care services, methods for identifying system-based errors and implementation of systems-based solutions, and a focus on a patient-centric approach.

Finally, should any efforts to identify and establish performance measures related to any aspect of GME funding be undertaken in the future, ASN would encourage that the primary objective of any performance-based system should be to improve performance, not to hinder the ability of the entities being assessed to achieve those measures and not to generate savings. Of course, any measure of development efforts must always include input from the breadth of affected stakeholders and be conducted in an open and transparent process.

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?

Patient with chronic kidney disease are heavily represented in socioeconomically disadvantaged populations, both in urban and rural settings. ASN advocates strongly for these vulnerable patients, and believes it is essential to maintain their access to care. To ensure that trainees are able to address the nation's health care needs, it is important to offer training in both rural and urban settings. However, the presence of training opportunities in underserved settings cannot overcome other factors alone that influence a graduate's job location. Additional resources that provide loan forgiveness to nephrology trainees might improve the attractiveness to practice in these areas. Attracting a workforce that has connections to underserved areas will create a more diverse provider base, another important goal for nephrology considering the diversity of the kidney patient population.

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

As noted above, the current financing system helps ensure access to specialists by providing funding for training beyond initial certification. Maintaining support for secondary certification structure is crucial to sustaining an appropriate number of specialists to care for the growing number of complex, chronically ill patients in the United States as well as defending the pipeline of clinician-scientists to develop and discover future cures.

ASN would also recommend against congressional efforts to legislate the specialty composition of training positions, which could inhibit training programs from adapting to the evolving workforce needs of the American patient population. That said, the society recognizes that certain areas of the country have struggled to attract an adequate number of nephrologists to meet patient care needs. Several Health Resources and Services Administration (HRSA) programs have proved successful in attracting clinicians to practice in health professions shortage areas—primarily through scholarship and loan repayment programs—and in certain programs permit states to define their own underserved areas and specific care needs.

To date such programs have focused on primary care needs. However, allowing states to also designate underserved areas for specialty care such as nephrology could potentially help ensure access to specialist care for patients and address the lack of interest in nephrology careers. As the American Association of Medical Colleges observes, HRSA “programs serve as a catalyst for innovations in education and training, helping the workforce adapt to the nation’s changing health care needs over the programs’ 50-year history.” Although such HRSA programs are not a component of GME per se, they may be worth considering as a more effective, nimble mechanism to guide the specialty composition of training positions than any potentially more permanent policy.

Ensuring an adequate supply of skilled basic and clinical scientists is an equally important goal. In order to remain globally competitive and develop the cost-effective cures of the future, investing in loan repayment programs not only for caregivers but also for trainees who are preparing for a career as investigators.

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

As described above, recent innovations in medical education abound, with increasing focus on competency-based, rather than time-based education. Furthermore, the accreditation process also has transitioned to outcomes- and competency-based requirements. Training programs are closely monitored and driven by national profession-sanctioned efforts and also receive guidance on training efforts and curricula from national professional societies such as ASN.

In the response to question two, ASN articulates principles that should guide the development of any measures to promote accountability or quality. Additionally, the society cautions that utilization of one-size-fits-all measures that do not necessarily reflect local and/or specialized needs could inadvertently penalize facilities that are actively addressing the population’s health care needs. Certain training programs are nationally recognized for focusing on a relatively narrow range of specialties and for training residents in a metropolitan region (such as cancer

hospitals, pediatric cancer/research institutes, rehabilitation hospitals), whereas other institutions support a diversity of training types. Moreover, the complex personal factors that largely determine specialty choice—and the decision to focus on clinical care versus research—are outside the scope of an institution’s influence. As such, establishing “accountability” metrics that aim to prioritize one discipline or one training setting over others inadvertently could hamper efforts to improve other facets of the health care system, such as medical and scientific discovery.

Again, ASN thanks the Committee for its interest in the efficiency and stability of the GME system and hopes that these comments have been helpful. The society stands ready to provide additional information—including the George Washington University series of reports regarding the state of the nephrology workforce and future care needs—or answer any questions the Committee may have. To discuss ASN’s comments, please contact ASN Manager of Policy and Government Affairs Rachel Meyer at rmeyer@asn-online.org or at (202) 640-4659.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jonathan Himmelfarb', with a large, stylized initial 'J'.

Jonathan Himmelfarb, MD, FASN
President