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June 24, 2024

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

RE: Bipartisan Medicare GME Working Group Draft Proposal Outline and Questions for Consideration

Dear Chairman Wyden and Ranking Member Crapo:

The American Society of Hematology applauds the Senate Finance Committee ("the Committee") for releasing a policy outline describing improvements to the Medicare Graduate Medical Education (GME) program to address physician workforce shortages across the country. We appreciate the Committee's work to develop a legislative solution to expand and improve the distribution of Medicare-supported GME training positions to rural areas and specialties in shortage, like hematology.

ASH represents more than 18,000 clinicians and scientists worldwide who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell disease (SCD), thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the fields of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy.

Our mission is to foster high-quality, equitable care, transformative research, and innovative education to improve the lives of patients with blood and bone marrow disorders. As part of this mission, ASH is committed to addressing the shortage of hematologists. In 2019, ASH published findings from a three-year longitudinal study investigating the hematology workforce, with a focus on recruitment, to address the profound need for additional hematologists.[1] The study found that medical school plays a significant role in shaping hematology-oncology fellows' interest in pursuing careers in hematology and highlighted the importance of hematology mentors during medical education and training. Importantly, the study found that only a small percent of students showed interest in non-malignant hematology, also known as classical hematology. This area of hematology focuses on blood diseases and conditions other than blood cancers, such as

SCD, hemophilia, thalassemia, anemia, and other bleeding and clotting disorders. These diseases and conditions affect millions of individuals and have substantial morbidity and mortality. For example, in the United States, according to the Centers for Disease Control and Prevention, venous thromboembolism (blood clotting) affects up to 900,000 people per year and kills 60,000 to 100,000 people per year. Anemia affects an estimated 2.8 million people per year and is the primary diagnosis for an estimated 800,000 emergency visits per year. Both of these common conditions are highly comorbid with other deadly conditions such as cancer and heart disease; affect maternal health; and have a disproportionate impact on minority populations. Among rare diseases, SCD is the most common, affecting approximately 100,000 people in the United States and causing substantial morbidity. ASH's workforce study findings together with data about morbidity and mortality related to hematologic conditions motivated ASH to proactively address the supply of classical hematologists.

ASH created the Hematology-Focused Fellowship Training Program (HFFTP) to help increase the number of fellowship programs that prioritize training and careers in nonmalignant, classical hematology. The HFFTP is a pathway that offers physicians the opportunity to pair comprehensive classical hematology training with career-enhancing education in several related areas. Funded entirely by ASH, ten new hematology-focused fellowship tracks were created at nine institutions across the country. The HFFTP aims to strengthen the next generation of hematologists, with an initial goal of producing nine new fellowship programs and fifty new academic hematologists by 2030.

It is within this context that the Society provides comments in response to the Committee's draft proposal outline and questions for consideration. Our comments, focused on Sections 2, 3, 4, and 7, are as follows:

Section 2. Additional and Improved Distribution of Medicare GME Slots to Rural Areas and Key Specialties in Shortage

ASH appreciates the investments made by Congress to add 1,200 new Medicare-supported GME slots as authorized by the Consolidated Appropriations Act (CAA), 2021 and CAA, 2023. This was the first increase in slots since 1996 and ASH applauds the Committee for continuing this progress by considering the authorization of additional Medicare GME slots over five fiscal years to address physician workforce shortages. While the Committee proposal does not specify the quantity of additional slots, increasing the number of training slots will be essential to meet the growing healthcare needs of our country. Recent projections published by the Association of American Medical Colleges show that the United States will face a physician shortage of up to 86,000 physicians by 2036.[2] ASH encourages the Committee to take projections like these into account, as well as retirement trends in different specialties and the rates of the country's growing and aging population.

ASH recognizes that the Committee's proposal includes a provision that prioritizes the distribution of training slots to primary care and psychiatry/psychiatry subspecialty residency programs by providing 25% of new slots to primary care and 15% of new slots to psychiatry/psychiatry subspecialties. Similar to primary care physicians, hematologists face many challenges including workforce shortages driven by medical school debt and reimbursement rates set by Medicare, Medicaid, and private insurance. Therefore, ASH encourages this Committee to seek solutions that apply to physician shortages beyond primary care and psychiatry or psychiatry specialty residencies. ASH recommends that the distribution of slots set aside for primary care and psychiatry not exceed the proposed 40% to ensure that there

[1] Leah E. Masselink, Clese E. Erikson, Nathan T. Connell, Laura M. De Castro, Georgette A. Dent, Ariela L. Marshall, Rakhi P. Naik, Marquita Nelson, Casey L. O'Connell, Anita Rajasekhar, Deva Sharma, Melody Smith, Alfred Ian Lee; Associations between hematology/oncology fellows' training and mentorship experiences and hematology-only career plans. Blood Adv 2019; 3 (21): 3278–3286. doi: https://doi.org/10.1182/bloodadvances.2019000569

[2] https://www.aamc.org/media/75236/download?attachment

will be a sufficient number of slots to address the persistent shortages across other specialties and subspecialties, such as hematology.

Workforce projections from the Health Resources and Services Administration (HRSA) National Center for Health Workforce Analysis forecast that by 2036, non-metropolitan areas are projected to have only 37% of the required number of hematology and oncology physicians needed to adequately meet the healthcare needs of the population.[3] This highlights a significant shortfall in the availability of hematology and oncology specialists in rural areas compared to metropolitan areas. Therefore, we share the Committee's goal to support training in rural areas and hospitals by amending the GME allocation formula enacted in the CAA, 2023. A more accurate calculation of rurality combined with the need for subspecialists (such as hematologists) is needed to better address healthcare disparities and improve access to care in rural communities.

ASH recognizes that Section 2 of the proposal would maintain other aspects of the GME allocation formula enacted in the CAA, 2023. Previous distribution methodologies used by the Centers for Medicare & Medicaid Services have awarded residency positions to qualifying hospitals based on the Health Professional Shortage Area (HPSA) score of the area served by the residency program. Programs serving areas with higher HPSA scores receive higher prioritization for additional GME slots. ASH has concerns regarding the methodology and geographic boundaries used to calculate HPSA scores and suggests exploring alternative metrics that consider areas of the country where shortages of physicians are most acute, and where higher rates of mortality, such as maternal mortality, are pervasive. When considering the distribution of residency and fellowship positions, we believe it would be beneficial to take mortality data into account alongside data on the prevalence of complicated and chronic diseases affecting underserved communities. In hematology, this would include SCD and other hemoglobinopathies. Individuals with SCD are living longer (average life expectancy is 52.6 years[4]) but unfortunately, many receive uncoordinated, inconsistent care, leading to poor clinical outcomes, avoidable complications, low quality of life, and increased costs to the healthcare system. Women with anemia, women on blood thinners to control blood clots, women with blood cancer, and women with sickle cell disease (SCD) are especially at high risk of pregnancy related complications including death; and, women with SCD are 10 times more likely to die in childbirth than Black women without SCD.[5],[6] This approach –to consider morbidity and mortality data –would broaden traditional HPSA delineations and is critical to explore, given the need for hematology and other specialty care in identifiable communities.

Furthermore, ASH recognizes that the Committee included a provision under this section which would direct the Secretary of the Department of Health and Human Services (HHS) to prioritize new Medicare GME slots for hospitals that are affiliated with a center of excellence, a historically black college or university (HBCU), or other minority serving institution (MSI) that establishes a medical college in order recruit physicians who are more likely to work in a rural or underserved community long-term. Physicians trained at HBCUs and MSIs are more likely to be from minority backgrounds themselves and are often more attuned to the specific health challenges and social determinants of health that affect these populations. Therefore, we commend the Committee's creative approach to ensuring that new trainees ultimately practice in and meet the healthcare needs of underserved communities. These

[3] Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

[4] Jiao B, Johnson KM, Ramsey SD, Bender MA, Devine B, Basu A. Long-term survival with sickle cell disease: a nationwide cohort study of Medicare and Medicaid beneficiaries. Blood Adv. 2023 Jul 11;7(13):3276-3283. doi: 10.1182/bloodadvances.2022009202. PMID: 36929166; PMCID: PMC10336259.

[5] Oteng-Ntim E, Meeks D, Seed PT, et al. Adverse maternal and perinatal outcomes in pregnant women with sickle cell disease: systematic review and meta-analysis. Blood. 2015 May 21;125(21):3316-3325. doi: 10.1182/blood-2014-11-607317. ePub 2015 Mar 23. PMID: 25800049.

[6] Villers MS, Jamison MG, De Castro LM, James AH. Morbidity associated with sickle cell disease in pregnancy. Am J Obstet Gynecol. 2008 Aug;199(2):125.e1-e5. doi: 10.1016/j.ajog.2008.04.016. ePub 2008 Jun 4. PMID: 18533123.

are important topics for exploration, and we welcome the opportunity to work with the Committee to review the data and practice patterns to ensure policy proposals like these and others meet the needs of these communities.

Section 3. Encouraging Hospitals to Train Physicians in Rural Areas

ASH appreciates the Committee's recognition that residency programs in rural areas face unique challenges that residency programs in urban areas do not encounter. Residency programs and teaching hospitals in rural and underserved areas often struggle with recruitment and retention of residents due to remote locations and other lifestyle factors. Additionally, these programs have greater financial constraints and limited resources that may impact the availability of experienced faculty and mentors, thereby affecting trainees' learning experience.

For these reasons, ASH supports the provisions included in this section which would allow community hospitals (SCHs) and Medicare-dependent hospitals (MDHs) serving rural communities to receive IME payments. Currently, these hospitals only receive direct GME payments. This additional payment would help these hospitals cover training expenses, and in doing so this would enhance the hospitals' capacity to provide medical education and improve the delivery of services in rural areas. This section would also extend the ability of teaching physicians to use telehealth to supervise resident physicians beyond December 31, 2024. Many hematologic diseases are complex to manage, and ongoing patient care poses significant challenges. Patients living in rural areas may not have access to hematologists in their communities, and telehealth can help patients receive appropriate specialty care regardless of where they live. Allowing teaching physicians to use telehealth to supervise residents and fellows will greatly benefit hematology training programs from the supervision of experienced hematologists who are not otherwise available. Telehealth is a modern solution to a vexing problem for rural areas, enhancing the quality of medical education and patient care.

Section 4. Establishment of Medicare GME Policy Council to Improve Distribution of Slots to Specialties in Shortage

As outlined in the Committee's proposal, this provision in Section 4 would direct the HHS Secretary to establish a time-limited GME Policy Council (the "Council") consisting of 9 members representing academic medical institutions, hospitals that serve rural areas and underserved communities, medical students, and health care workforce experts. The Council will be required to evaluate the distribution of new Medicare GME slots made available under this bill and make recommendations to the HHS Secretary regarding the distribution of the new Medicare GME slots added by this bill. ASH believes this proposal demonstrates a thoughtful approach to addressing the distribution of new Medicare GME slots and recommends that the Council include at least one member who can evaluate these policies from the perspective of cognitive specialties, like hematology, that are increasingly important to the aging and medically complicated Medicare patient population.

Section 7. Improving GME Data Collection and Transparency

The provision in Section 7 aims to address the lack of accountability and transparency in the Medicare GME program by requiring the HHS Secretary, in consultation with the Secretary of the Department of Veterans Affairs (VA), to submit an annual report to Congress and create a public database on federal GME programs by requiring teaching hospitals to report specific information including resident demographics, Medicare GME payments, and outcomes of residency programs. Additionally, this provision requires HHS to analyze and assess how Medicare GME investments address projected shortages by state, using the new public database. ASH supports this provision because we believe that comprehensive reporting from this type of public database will increase transparency and allow for greater understanding of GME programs and improved resource allocation, to help address physician shortages more effectively.

Thank you for the opportunity to provide comments on this draft proposal. We look forward to working with the Senate Finance Committee to address physician workforce shortages across the country and improve patient access

to medical care. Should you have any questions or wish to discuss these ideas further, please use Suzanne Leous, ASH Chief Policy Officer at sleous@hematology.org or 202-292-0258, as your point of contact.

Sincerely,

Mohandas Narla, DSc

President

Mary-Elizabeth M. Percival, MD

Chair, Committee on Practice