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The Honorable Joe Pitts
Chairman, Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Gene Green
Ranking Member, Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Energy & Commerce Committee
U.S. House of Representative
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Peter Welch
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable H. Morgan Griffith
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Kathy Castor
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pitts, Ranking Member Pallone, Ranking Member Green, and Representatives DeGette, McMorris Rodgers, Welch, Griffith, and Castor:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to respond to the Dec. 6 Open Letter Requesting Information on Graduate Medical Education (GME). The AAMC is a not-for-profit association representing all 141 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC is grateful for your commitment to preserving patient access to care by assuring an adequate physician workforce, most recently evidenced by the Subcommittee's leadership in advancing the Children's Hospital GME Support Reauthorization Act (P.L. 113-98). Throughout the years, the Committee has

demonstrated a bipartisan commitment to strengthening federal support for health professions education and training, including Children's Hospitals GME, the National Health Service Corps (NHSC), workforce development programs under Title VII of the Public Health Service Act, and other initiatives under the Committee's jurisdiction.

Beyond its work to support medical education, the Committee's accomplishments with respect to promoting scientific discovery through medical research and facilitating outstanding clinical care also have had a profound impact on academic medical centers and the millions of Americans nationwide who turn to these institutions for the latest advances in medicine. Guided by a tripartite mission of medical education, medical research, and clinical care, medical schools and teaching hospitals train the majority of the nation's physician workforce, conduct more than half of the extramural research supported by the National Institutes of Health (NIH), operate the vast majority of the critical stand-by and highly specialized services communities rely upon, and treat the most medically vulnerable patients from all socioeconomic backgrounds. Federal GME support is an essential component in enabling these institutions to continue this important work, and the AAMC has endorsed legislation to strengthen the transparency and accountability associated with this funding.

As a result of their fundamental role in the U.S. health care system, the training environment at academic medical centers is characterized by experience working in multidisciplinary and multiprofessional teams; regular interaction with a diverse array of patients, conditions, and care settings throughout the community; and critical thinking skills refined by a culture of continual improvement. Much like they are leading innovations in clinical care and forging ahead toward the frontiers of medical science, medical schools and teaching hospitals are working to transform medical education in a manner that prioritizes quality, patient safety, and access. While some of these efforts may require new legislation to maximize their effect, many already are being driven by accreditors, the market, or academic medical centers themselves.

The AAMC appreciates the signatories' interest in better understanding the public and private investment in GME, as well as the recent report by Institute of Medicine (IOM)-appointed committee. As Members review the report and input from other stakeholders, we encourage you also to consider the accompanying AAMC comments recently submitted to the IOM committee. While the AAMC shares the committee's vision of the future physician workforce, we note that the report's recommendations to achieve that vision will have unintended consequences for both medical education and patient access to care. Those consequences are understated in the committee's report.

Moreover, due to the inherent complexity of GME financing, some commentators inadvertently base their recommendations on incomplete, inaccurate, or misinformed premises. For example, some stakeholders have suggested that shortcomings in the workforce, such as geographic distribution, can be resolved through changes to GME financing, but these suggestions are not fully supported by past experiences. Others are

relying on care delivery models in the Affordable Care Act as the silver bullet to resolve physician shortages despite data and demographics to the contrary. Some observers expect that government interventions to micromanage specialty composition can outweigh the highly complex personal factors – such as personal interest and lifestyle – that drive physician career choices.

We hope the AAMC's detailed comments on the IOM committee's report will prove useful to you in clarifying these misunderstandings and in describing the initiatives already underway at medical schools and teaching hospitals nationwide. Similarly, we are pleased to provide the following responses to the questions you posed, with a particular focus on legislative strategies to strengthen the nation's physician workforce. Most of these suggestions are addressed in greater depth in the AAMC's comments on the IOM committee report. The AAMC also would welcome the opportunity to discuss the issue with you further at your convenience.

The AAMC is grateful for the opportunity to answer these questions and we look forward to ongoing discussions with the Committee. Please do not hesitate to contact AAMC Chief Public Policy Officer Atul Grover, M.D., Ph.D., at 202-828-0666 if we can be of further assistance.

Thank you again for your leadership in assuring patient access to care and your support for the unique missions of academic medicine. We stand ready to partner with you in achieving our mutual goal of improving health and health care for all.

Sincerely,

Darrell G. Kirch

Darrell G. Kirch, M.D.

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

To efficiently and effectively meet the nation's health care needs, the physician pipeline must expand. As record numbers of Baby Boomers enter the Medicare system, the demographics of the population will strain the health care system over the next decade by increasing the demand for physician services as the physician workforce also ages. Changing practice patterns and other efficiencies in health care delivery may mitigate shortages over the long term, but in the interim, data to support these assumptions is not definitive and transformation will take time. The resulting shortfalls in the meantime will affect all Americans, and, as recently illustrated by tragic headlines from the Department of Veterans Affairs (VA), the most vulnerable populations in underserved areas will be the first to feel the effects.

Despite successful efforts of existing and new medical schools to address physician shortages by increasing enrollment, residency training positions at teaching hospitals have not grown at the same pace, because they are limited by the cap on Medicare support imposed by the Balanced Budget Act of 1997. Hence, while demand for health care services will grow, there will not be commensurate growth in supply, leading to shortages. Most non-teaching hospitals currently are able to become teaching hospitals and receive Medicare support, but only 17.7 percent of hospitals nationwide choose to do so, and major teaching hospitals represent only 5 percent of all hospitals. Thus, lifting the cap on Medicare-supported residency positions would enable teaching hospitals that are willing and prepared to train physicians to begin expanding their programs immediately. The medical education community recognizes the need to be accountable and transparent throughout the expansion.

At the same time that support for physician training should be increasing, major teaching hospitals are facing significant financial pressures from clinical payment reforms, sequestration, and other sources. This includes threats to cut Medicare GME support. As noted below, Medicare GME supports only a portion of the costs associated with training residents. Teaching hospitals must fund the remaining costs through their clinical revenues, and financial pressures will make that difficult to continue. According to the results of an August 2013 survey of GME program directors by the Accreditation Council for Graduate Medical Education (ACGME), 83 percent of respondents (from both teaching hospitals and medical schools) are already engaged in leadership-level discussions about how they would reduce residency positions in both primary and specialty care if Medicare GME support were reduced.

Preserving existing and reliable Medicare support for these institutions is vital to efficiently and effectively train the next generation of physicians, without jeopardizing the equally important research and clinical missions at academic medical centers. As the committee is aware, funding residency training through unreliable annual appropriations (e.g., CHGME), eliminates the long-term stability necessary to train residents. The AAMC expressed this concern when the Committee voted in 2011 to defund the

mandatory appropriation for the Teaching Health Center (THC) program, which would have destabilized the Health Resources and Services Administration (HRSA)'s ability to support the multi-year THC residencies.

While we believe that current GME support through Medicare, Medicaid, CHGME, and other federal programs should not be reduced or redirected, we do believe that introducing additional stability for existing and expanded physician training efforts should be a top priority for the nation. To date, payers beyond Medicare and teaching hospitals have contributed relatively less to cover the costs of graduate medical education. Medicare itself covers *only its share of the costs*, less than a quarter of direct costs teaching hospitals incur, rather than the full costs of training. In venues with low numbers of Medicare discharges, Medicare may not be the appropriate source for GME funding. Other federal programs do not provide comparable levels of support, while private payers contribute little to no explicit funding to offset the costs of physician training and unique clinical missions at teaching hospitals. As a result, the current mechanism for financing GME does not reflect the full spectrum of entities benefiting from the product of such investments.

The AAMC first endorsed "all-payer" support for GME decades ago, when the association called for "broad-based societal support" and "shared responsibility" funds for physician training. We continue to welcome the opportunity to work with stakeholders toward a system that augments the existing investments in physician training. We note, however, that any such system must build upon the existing infrastructure for financing GME to prevent destabilizing the training enterprise at a time when the nation needs more physicians and clinical revenues erode further. Any efforts to reform GME financing should supplement, rather than replace, existing funding sources. Eliminating existing funding streams risks diluting or forfeiting the targeted focus that each program was intended to address. In the meantime, it will be essential to expand existing support for physician education, as described in question #2, to resolve current and future shortages.

Our responses to questions #3 and #4 describe the limitations in using GME financing mechanisms to influence programmatic outcomes, which are better addressed through educational and other interventions. Across the continuum, medical education has changed significantly in the last 15 years and continues to change. For example, there is increasing focus on competency-based education in which trainees advance as they achieve necessary milestones, as opposed to time-based advancement. Initiatives are underway to enhance admissions processes, policies, and practices to better identify, select, and prepare tomorrow's doctors for the health care system – and patient population – of the future. Education across multiple health professions is being better integrated and coordinated to provide more collaborative and patient-centered care.

Changes to the accreditation process seek to facilitate and accelerate this transformation in medical education. The AAMC supports ACGME's transition to outcomes- and competency-based accreditation through its Next Accreditation System (NAS). The NAS requires programs to demonstrate that trainees have achieved competence in six clinical

competency domains: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Additionally, the ACGME's Clinical Learning Environment Review (CLER) program is intended to "generate national data on program and institutional attributes that have a salutary effect on quality and safety in settings where residents learn and on the quality of care rendered after graduation," as described by ACGME leadership. These goals are best achieved in a framework that is guided by educational rather than political objectives.

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?

In the 113th Congress, the AAMC endorsed bipartisan GME expansion bills that would direct new GME funding to shortage specialty residency programs and would prioritize communities that have invested in new medical schools. These bills include the *Resident Physician Shortage Reduction Act* (S. 577 and H.R. 1180) and the *Training Tomorrow's Doctors Today Act* (H.R. 1201). The modest expansion proposed in these bills would enable teaching hospitals to train more physicians, but only about one-third of the additional physicians required to abate expected physician shortage. Nearly two dozen physician and other organizations endorsed the bill, including groups representing primary care physicians and groups representing specialists.

To address physician shortages in real-time, these bills would require half of all newly available residency slots to be dedicated to "shortage specialty" residency programs identified by an independent third party. Other criteria for distribution of new slots would include hospitals affiliated with medical schools that have at least 40 percent of graduates matched in a primary care residency program in the 5 years prior; hospitals emphasizing training in community and outpatient settings; and hospitals eligible for electronic health record (EHR) incentive payments.

H.R. 1201 also includes provisions to establish accountability and transparency measures in accord with recommendations issued by MedPAC. Specifically, H.R. 1201 directs the Secretary of the Department of Health and Human Services (HHS) to implement a Medicare Indirect Medical Education (IME) payment adjustment based on whether a teaching hospital trains residents in clinical care environments that model:

- A variety of clinical settings and systems;
- Multispecialty and interprofessional teams;
- The relevant cost and value of diagnostic and treatment options;
- The delivery of evaluation and management (versus procedural) services;
- Methods for identifying system-based errors and implementing system-based solutions; and
- Other "patient care priorities."

The bill calls for a process to identify and establish performance measures that are consensus-based, incorporate qualified stakeholders, and are consistent with the efforts of the GME accrediting bodies. The AAMC strongly believes that to be maximally effective, any accountability reporting and measures should be consistent with data already being collected for federal quality metrics, by the ACGME for accreditation purposes, and other initiatives.

To incentivize adoption of these patient care priorities without destabilizing institutions' ability to serve their communities, the IME performance adjustment program in H.R. 1201 would allow the Secretary to reduce by up to 2 percent IME payments for hospitals that do not meet performance standards. The AAMC believes this approach holds the most potential to meaningfully demonstrate the ongoing accountability of teaching hospitals for the public funds they receive without inadvertently undermining the nation's physician training enterprise. The 2 percent figure also would make the IME performance adjustment program consistent with the percentage of funding at risk under other federal pay-for-performance programs such as Medicare's Value-Based Purchasing Program (2 percent) and Physician Quality Reporting Program (2 percent).

Placing substantially more than 2 percent of an institution's GME payments at risk from year to year likely would yield unintended consequences. Prudent fiscal planning would force even the best-performing institutions to budget for the maximum cut to ensure their ability to sustain their programs and services in the event of a substantial loss. The risk would be compounded by cuts already being imposed on teaching hospitals as a result of sequestration and new Medicare payment methodologies. Accordingly, institutions may reassess the viability of continuing their costliest efforts under extreme financial pressures, as some reports, such as the ACGME survey results discussed above, already have begun to indicate.

We believe you will agree, the primary objective of any performance-based system should be to improve performance, not to undermine the ability of the entity to achieve those measures and not to generate savings. Instituting a system that puts an unreasonable percentage of an institution's budget at risk would erode the financial resources necessary to provide patients life-saving services unavailable elsewhere in the community; destabilize the infrastructure for education, research, and patient care; and penalize trainees.

H.R. 1201 also incorporates legislative changes to enhance the transparency associated with Medicare's support for graduate medical education. Under H.R. 1201, the HHS Secretary would be required to issue an annual report on Medicare GME payments, including data on:

- DGME and IME payments made to each hospital;
- DGME costs of each hospital, as reported on the annual Medicare cost reports;
- Number of full-time equivalent residents (FTEs) at each hospital that are counted for DGME and IME purposes;
- Number of FTEs at each hospital that are not counted for DGME and IME purposes; and

- Factors contributing to the higher patient care costs at each hospital, including the:
    - Costs of trauma, burn, and other stand-by services;
    - Provision of translation services for disabled or non-English speaking patients;
    - Costs of uncompensated care;
    - Financial losses with respect to Medicaid patients; and
    - Uncompensated costs associated with clinical research.

In the 113th Congress, AAMC also endorsed a number of bipartisan non-Medicare solutions to address workforce issues, such as the "Creating Access to Residency Education Act of 2014" (H.R. 4282), the "Building a Health Care Workforce for the Future Act" (H.R. 5458/S. 1152), and the "Restoring the Doctors of Our Country Through Scholarships (RDOCS) Act" (H.R. 5223). H.R. 4282, introduced by Congresswoman Castor, would authorize a new program that would provide federal matching grants to support targeted priorities in residency training. H.R. 5458 and S. 1152 would address factors that influence specialty choice by establishing programs supporting primary care mentorship, educational innovations in priority areas, and scholarships building on the success of the NHSC. The bill also would study the effect of burdensome documentation requirements on the practice environment. H.R. 5223 would expand on the NHSC by providing state-based scholarships for primary care physicians in underserved communities. Though these proposals do not directly affect Medicare GME, they reflect the multi-faceted approach needed to support a comprehensive, effective national workforce strategy that best meets the population's changing health care needs.

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?

To ensure the workforce is best prepared to respond to the nation's health care needs, it is important to recognize the value of training in both urban and rural communities, in both inpatient and outpatient settings, and in both highly specialized and routine care. There is a clear need to improve the distribution of the physician workforce. Reviewing existing GME policies that facilitate such efforts demonstrates that factors beyond GME financing may be preventing expansion in chronically underserved areas. Further, by itself, the existence of training opportunities in underserved settings cannot remedy non-educational obstacles also affecting physician distribution.

Current policy incentivizes GME expansion in rural areas. Critical Access Hospitals (CAHs) that train residents are reimbursed at 101 percent of their reasonable costs, while other teaching hospitals receive formula-based payments that cover a small fraction of the institution's actual direct costs. Unlike other teaching hospitals for which Medicare support has been limited at 1996 levels since 1997, the "caps" for rural hospitals were set at 130 percent of their 1996 levels, leaving them significant room to grow their training

programs. The Medicare program also allows rural hospitals to expand their cap for the purposes of adding new medical residency programs. In other words, a rural hospital can add a new residency training program at any time and receive enhanced Medicare support for the new trainees, while Medicare support for other hospitals is limited by the caps established nearly two decades ago. Similarly, Medicare caps do not apply to CAHs; these hospitals can expand existing programs or add new programs without limit and will continue to receive Medicare support.

Additionally, as mentioned above, many non-teaching hospitals in rural and urban settings alike are able to become a teaching hospital at any time and receive Medicare support. However, only a small fraction choose to do so. AAMC staff has published a guide on the Medicare requirements for *Becoming A New Teaching Hospital* and regularly works with hospitals that are considering becoming new teaching hospitals and medical schools seeking to develop educational partnerships with non-teaching hospitals. Some stakeholders suggest that a concentration of training dollars in the Northeast reflects a geographic skew in current policy; however, under current law, there is in fact greater opportunity for hospitals in Western states such as Utah, Wyoming, and Montana to expand because fewer hospitals already have chosen to establish training programs compared to Northeastern states such as Pennsylvania or New Jersey (please see pg. 23 of AAMC comments to the IOM committee for a state-by-state breakdown).

Reports suggest the added costs associated with being a teaching hospital and the ongoing administrative burden of operating a high quality training program make the task daunting for any institution, even with the special payments and regulatory exceptions for rural hospitals and CAHs. For rural communities – which struggle to attract and retain physicians for a number of reasons – the task may be even more challenging. Aside from questions of securing the appropriate infrastructure for maintaining such a program over the long term, including sufficient supervisory faculty and equipment, it is not clear whether the volume and diversity of patient cases in such settings would offer ample opportunities to ensure a high quality, well-rounded educational experience. These types of challenges and expenses are not resolved by directing Medicare GME funding to any type of training facility, but rather must be addressed through other means.

Potential strategies to overcome some of these obstacles might include exploring whether providing non-teaching hospitals start-up assistance would make it more appealing for such facilities to administer training programs. Opportunities also may exist to develop and support programs to prepare community physicians to serve as educators, mentors, and training program administrators.

One existing policy that strives to alleviate some of these challenges is the Medicare Rural Training Track (RTT) program. The program provides mutually beneficial incentives for urban hospitals, rural hospitals, and non-hospital clinical settings to form partnerships through separately accredited RTT programs to train primary care residents to practice in rural areas. Urban hospitals participating in the program are allowed to receive additional GME funding above their cap for the time RTT residents train at their institutions – a rare exception to the 1997 law that set the cap. The rural hospitals also

receive Medicare GME funding on the basis of the time RTT residents train at their institutions; additionally, the rural participants are able to share the accreditation and other costs/responsibilities with the urban facility.

Recruiting residents to an urban-rural hybrid program may also prove easier than recruiting to a program that is exclusively rural, perhaps addressing the pipeline issue described above. Residents in RTT programs must train at the rural site for more than half of their training – and, in practice, likely spend two-thirds of their time in rural communities.

The Medicare regulations governing establishment and operation of rural training tracks are exceedingly complex. AAMC staff have produced resources to help guide institutions that may be interested in exploring a rural track. Exploring how best to expand the reach of established policies (such as the RTT program, the ability of rural hospitals to grow their caps, and the ability of non-teaching hospitals to establish a new residency program) will be important in determining whether optimizing these existing incentives will yield the desired outcomes.

Given the preference of practicing physicians for urban and suburban settings, it would be reasonable to expect similar partiality among medical graduates; indeed, recruiting graduates to fill residency positions in rural areas traditionally has been difficult. Even graduates who complete training in those communities do not necessarily stay; in 2012, Wyoming retained only 27.7 percent of physicians who completed GME in the state, Iowa retained 36.4 percent, and New Mexico retained 39.1 percent.

While opportunities to train in an area should be an important element of any state's workforce strategy, these retention numbers suggest that the availability of training positions alone cannot be expected to overcome the numerous other factors that influence a graduate's final practice location. Efforts to improve physician distribution cannot rely solely on educational interventions, but rather should prioritize the types of strategies that have demonstrated effectiveness, such as financial incentives to practice in underserved areas. Further, addressing physician distribution will only be complicated more in the midst of the significant shortages facing the nation.

4. Is the current financing structure for GME appropriate to meet current and future healthcare 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 current formulas or structure that would increase the availability of training slots and be responsive to current and future workforce needs?**

Stakeholders sometimes confuse the distinct purposes of Medicare direct graduate medical education (DGME) payments and indirect medical education (IME) payments, perhaps because they both are labeled "education" payments despite their differing purposes. As you know, DGME payments cover training expenses such as resident stipends and benefits, faculty salaries and benefits, and allocated institutional overhead costs. Most teaching settings, including many community health centers, are currently eligible for DGME payments. Like teaching hospitals, those payments would be calculated based on the facility's Medicare share.

Medicare IME, on the other hand, constitutes a *patient care* payment designed to partially offset the unique costs associated with caring for highly complex, severely ill inpatients at teaching hospitals. Unlike DGME payments, IME payments are provided as add-on payments for patient care services on a per-Medicare-beneficiary-discharge basis. Thus, IME payments attempt to remedy a flaw in the diagnosis-related group (DRG)-based prospective payment system (PPS), which does not capture these unique additional expenses teaching hospitals incur by providing round-the-clock access to highly specialized and costly patient care resources in a wide range of services. While other entities may treat challenging patient populations, they do not provide the level of complex care or stand-by capacity provided by teaching hospitals, and their Medicare and Medicaid reimbursement is often cost-based; consequently, they do not suffer the payment shortfalls that the IME is intended to resolve.

This intent for IME payments is clearly stated in House and Senate report language from when Congress explicitly created the adjustment for teaching hospitals as part of Medicare's DRG-based PPS:

> This adjustment is provided in light of doubts … about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents …The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (House Ways & Means Committee Rept. No. 98-25, March 4, 1983, and Senate Finance Committee Rept. No. 98-23, March 11, 1983)

Disregarding the original intent behind the IME payment and using it for a new purpose would have major implications for the patients that seek stand-by and other unique regional services at AAMC-member teaching hospitals. Though they represent only 5 percent of all hospitals, these hospitals operate: 79 percent of Level 1 adult trauma centers; 68 percent of all burn care units; and 59 percent of pediatric-intensive care units (ICUs). Additionally, 87 percent of all lung transplant programs, 85 percent of all liver transplant programs, 78 percent of all heart transplant programs, and 68 percent of all bone marrow transplant programs are based at an AAMC-member teaching hospital. One-fifth of all services in cardiac surgery and 30 percent of cardiac intensive care beds

are based at these hospitals. Compared with physician offices and other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled or non-white. Other settings typically do not invest in such services in the same way as major teaching hospitals do, which explains why such facilities are not eligible for IME payments.

Recent headlines illustrate how the infrastructure afforded by these well-established referral patterns can strengthen the ability of the health care system to respond expeditiously to novel threats too. As described by the University of Nebraska Medical Center (UNMC) in recent testimony before the Energy and Commerce Subcommittee on Oversight and Investigations, for over a decade, UNMC and Emory University have been maintaining specially built isolation units to treat patients with serious infectious diseases – two of only three ready units in the country. Until this past summer, no patient had required the highly specialized capabilities of the units, but the institutions had invested substantially to conduct regular training exercises and maintain constant readiness, despite losing funding from other sources.

After treating the first Ebola patients in the U.S., both facilities made it a priority to share the knowledge they gained through the experiences such that it could be accessed by other hospitals in the U.S. and health professionals globally. With no scientifically verified treatment for the disease, U.S. patients have been receiving a range of experimental therapies, adding an additional element of complexity to their care that academic medical centers are uniquely qualified to manage. As institutions guided by a commitment to medical research and discovery, Emory and UNMC were able to navigate the intricacies associated with untested therapeutics, institute research protocols, and advance the care of patients. Their efforts serve not only to benefit the patients at hand but also to better inform efforts to treat Ebola virus disease worldwide.

Emory and UNMC also worked closely with state and federal health officials to help coordinate the government's response. When it became clear that treating Ebola required unique and extensive preparations beyond standard hospital readiness, the institutions advised the CDC as the agency worked with other hospitals to prepare. As a result of their experience in caring for the most complex patients (e.g., trauma, burn, etc.) and in administering research protocols, major teaching hospitals were able to gear up immediately. Of the 48 treatment facilities named as of December 31, 2014, by CDC, 44 are AAMC-member institutions. Their preparations for Ebola patients not only will strengthen the nation's response to other emerging threats, it also will yield real-time lessons on improving infection control within hospitals. While recently enacted emergency supplemental funding may help cover some of the immediate expenses these hospitals will incur, sustaining that level of heightened preparedness over the long term will require an institutional financial commitment that will persist long after supplemental sources have been exhausted.

Major teaching hospitals house expertise and equipment inaccessible elsewhere. Their specialized capabilities may vary from institution to institution, but their common commitment to research, education, and patient care enables this network of academic

centers to replicate and scale up such capabilities more rapidly than other facilities, as necessary. This capacity serves as an asset not only in times of unexpected public health emergencies, but also in addressing the personal health emergencies that communities encounter daily. It also carries a heavy expense for the institution that IME payments are designed to offset. In this way, the IME payment partially offsets the costs of offering irreplaceable patient care services to the community; this relief enables the institution to continue supporting the costly research and education missions that, in turn, inform and strengthen the facility's clinical effectiveness.

Consolidating the DGME and IME payments risks forfeiting the targeted and distinct purpose that each of these funding streams was intended to address. Without an alternative methodology to sustain the above-described specialized services, such action could jeopardize communities' access to life-saving care. The effects would extend far beyond the locale of the recipient institution, since, in many cases, major teaching hospitals are regional referral centers that provide irreplaceable specialized services not found in surrounding states.

In its most recent report, the federal Council on Graduate Medical Education (COGME) expresses similar concern about proposals (such as the one in the IOM committee's report) to eliminate IME payments. The COGME report states,

> The IOM Committee draws on past analyses finding that much of IME is not devoted to training and could be cut without harming the programs. However, COGME believes that IME funding helps support programs and activities that serve an important public health need. These funds may be inextricable from the maintenance of training programs. An across the board reduction in these amounts would significantly disadvantage patients and communities as well [as] GME trainees by reducing access to much-needed medical specialty care, particularly in disadvantaged and underserved communities.

Aside from the consequences of consolidating DGME and IME payments, proposals to restructure GME payments to "follow the resident" also have inherent flaws. For example, many educational and administrative expenses (e.g., data infrastructure for residency evaluation or simulation technology) are most efficiently and cost-effectively managed centrally by the institution. As training and documentation requirements change, the infrastructure also must be updated to fulfill quality and regulatory requirements. Teaching hospitals have the experience and administrative capacity to manage these extensive and expensive aspects of residency training. It would not be financially feasible for any individual training program to support that sort of infrastructure. Allowing GME funds to "follow the resident" would reduce the ability of teaching hospitals to maintain the mandated infrastructure.

Some stakeholders observe that DGME is underfunded, a consequence of outdated Medicare methodologies that underpay teaching hospitals for training and the absence of other payers explicitly contributing their share of training costs. The AAMC appreciates

the well-intended interest of these parties in remedying this flaw; however, the solution to this shortcoming should not come at the expense of patients and patient care. As described above, an all-payer mechanism could be one alternative. Congress might also consider instructing CMS to rebase a hospital's DGME payment on the basis of its most recent cost report, as another potential alternative to better reflect the true costs of DGME.

ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

A wide range of stakeholders has affirmed that factors other than GME financing are more powerful forces in influencing the specialty mix of physicians. In its report, the IOM committee indicates, "Health care reimbursement and the organization of health care services, for example, are far more important than GME in determining the makeup and productivity of the physician supply."

This conclusion is further supported by failed attempts to manipulate specialty selection through Medicare GME payments. Since the mid-1990s, hospitals have received twice the DGME payment for primary care and geriatrics residents as compared to subspecialty fellowships, yet shortages persist. As observed by MedPAC in its November 2003 report on the Impact of Resident Caps on the Supply of Geriatricians, "[f]actors other than Medicare's resident caps may better explain the slow growth in the number of geriatric physicians." The report further notes that "federal policies intended to affect the number, mix, and distribution of the health care workforce should be implemented through specific targeted programs rather than through Medicare."

Successful initiatives in promoting primary care careers include two that Committee members have championed over the years, both administered by HRSA: the National Health Service Corps (NHSC) and Title VII health professions programs.

As you know, the NHSC provides scholarships and loan repayment to health professionals in exchange for practicing primary care in federally designated health professions shortage areas (HPSAs). The NHSC improves access to health care for the growing numbers of rural and urban underserved Americans; provides incentives for practitioners to enter primary care; and reduces the financial burden that the cost of health professions education places on new practitioners.

With the Affordable Care Act's mandatory funding for NHSC set to expire at the end of FY 2015, the program is in jeopardy. The AAMC, as a member of the NHSC Stakeholders, supports further expanding the NHSC to supplement existing health professions training investments. A funding approach that includes both mandatory and discretionary funding ensures annual flexibility with out-year stability. The AAMC further requests that any expansion of NHSC eligible disciplines or specialties be accompanied by a commensurate increase in NHSC appropriations (while also preserving

the full spectrum of other federal health care workforce programs), so as to prevent a reduction of awards to current eligible health professions.

The AAMC also recommends expanding the authorization of the NHSC State Loan Repayment Program (SLRP) to allow states to define eligible sites and additional primary care needs. The NHSC SLRP provides matching funds to more than 30 states to operate their own loan repayment programs for primary care clinicians working in HPSAs. However, these funds are limited to the same specialties and underserved locations as the federal NHSC loan repayment program, providing states little opportunity to address workforce shortages unique to their situations. States are reluctant to commit additional funding from already-strained state budgets when significant increases in the federal NHSC programs can be used for identical purposes. With expanded SLRP authority, states can help appropriately identify sites that provide care to populations residing within HPSAs and direct funding to address their unique workforce needs.

While the NHSC is a critically important federal program, it is no more so than the Armed Forces health professions scholarship and loan repayment programs, the VA Education Debt Reduction Program, the Indian Health Service, and Department of Education's Public Service Loan Forgiveness program. These programs help students from all backgrounds attend medical school and serve as an important recruitment mechanism.

In addition to the NHSC, other HRSA programs have proven successful in guiding students toward a career in primary care and underserved communities. The Title VII health professions programs offer support for enhanced educational opportunities in these settings. The 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.

The Title VII programs continually have demonstrated merit in producing diverse, culturally competent primary care providers prepared to serve in the areas they are needed most. Moreover, the programs continue to be at the forefront of advancing changes in health professions training and education. The AAMC strongly supports a robust, reliable investment in the programs, which have suffered from chronic underfunding.

As stated by Congresswoman DeGette and Congresswoman McMorris Rodgers in FY 2010, "By reinvesting in the Title VII programs, you will enable them to continue to improve the distribution, quality, and diversity of the health professions workforce in a manner that is consistent both with the needs of the nation and the President's pledge to invest in strengthening the health care workforce." The tradition of bipartisan support for the programs continues today.

In the pre-cursors to the Affordable Care Act, the Committee had proposed stabilizing funding for Title VII, NHSC, and other discretionary workforce programs through a fund

that would supplement annual appropriations. Such a hybrid funding mechanism would maximize Congressional oversight and funding discretion while offering more financial stability to training efforts that require a multi-year commitment. Maintaining these investments outside of Medicare aligns not only with the different programs' policy intents, but also with the above-described findings that Medicare GME is not the most effective lever in addressing these needs.

Moving forward, the AAMC believes that prescribing the specialty composition of training positions in legislation would inhibit training efforts from adapting to changing workforce needs. Currently, projections indicate the nation faces significant shortages evenly spanning both primary and specialty care, but workforce needs fluctuate and change over time. Preserving workforce flexibility at the regional and local levels is the best way to ensure that organizations can continue to fulfill the multifaceted health needs of our aging nation, including, but not limited to, primary care.

Instead of attempting to micromanage specialty composition by locking it into the GME financing structure, the AAMC recommends ongoing analysis of population growth, regional and state-specific needs, and evolving changes in delivery systems to guide current and future targeting of funding for new residency positions. The AAMC-endorsed legislation referenced above (H.R. 1201/S. 577/H.R. 1180) follows a similar model, thereby allowing the training environment to adapt as demographics, delivery models, and health care needs change.

Also, as indicated elsewhere, the influence of complex personal factors on specialty choice should not be overlooked. Within reason, the AAMC supports the ability of individual medical students and physicians to determine which area of medicine best suits their personal and career goals and talents. Attempting to force graduates into targeted specialties by limiting training in other disciplines would have limited effect and, even if successful, could jeopardize patients' timely access to care. Education and training cannot overcome the intense market incentives that influence physician choices.

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

U.S. teaching hospitals are the model for physician training around the globe. As described above, innovations in medical education abound, with increasing focus on competency-based, rather than time-based education. The accreditation process also has transitioned to outcomes- and competency-based requirements.

In our response to question #2, we describe the legislation AAMC has endorsed to strengthen further the federal investment in GME, including the transparency and accountability associated with public funds (H.R. 1201).

Some well-intentioned stakeholders have proposed GME "accountability" measures as the primary means to resolve gaps in the workforce. Imposing administratively unfeasible

requirements on medical education programs, however, would not advance workforce planning goals in a meaningful way.

For example, in its recent report, COGME too prioritizes the need for enhanced transparency in GME funds, stating, "Transparency around the allocation of federal support, how programs use such funds, and the outcomes they achieve, could inform policy and drive program performance." At the same time, the council acknowledges that, in practice, it can be unrealistic to expect to draw reliable conclusions from investments and program "outcomes." The report continues that "linking program cost information with outcomes metrics requires a level of financial disclosure that even the most forth-coming training programs may find difficult, if not impossible, to provide."

Health needs and demands vary at the local level and also over time, and personal decisions (e.g., family demands, the careers of spouses, personal lifestyle choices) repeatedly have been identified as major factors in determining the specialty and geographic location in which a physician will practice. These complex personal factors are largely outside the scope of an institution's influence. It would be unreasonable to hold institutions responsible for tracking the outcomes of such decisions over long periods of time or to hold them accountable for factors over which they have limited control.

Additionally, imposing one-size-fits-all "accountability" measures that do not reflect local and/or specialized needs could inadvertently penalize facilities that are actively addressing the population's health care needs. It is important to keep in mind that some training programs are nationally recognized for focusing on a relatively narrow range of specialties and for training residents in a metropolitan region (e.g., cancer hospitals, pediatric cancer/research institutes, rehabilitation hospitals).

Likewise, 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. As you likely are aware through the Committee's commendable work on the 21st Century Cures initiative, an advisory group to the NIH recently concluded that the nation will not be able to sustain the physician-scientist workforce as current physician-scientists retire and clinical demands increase. You may not be aware that the pipeline of physician-scientists overwhelmingly is filled by trainees pursuing specialty disciplines. For instance, family medicine accounted for 1.03 percent of M.D.-Ph.D. active residents in 2013, disproportionately less than its representation among all active residents graduating from U.S. M.D.-granting schools. Thus, as one example of unintended consequences, a well-meaning "metric" to promote training in primary care could end up penalizing institutions that are successfully responding to other equally important national priorities.

Rather than imposing unreasonable measures on institutions, the AAMC advocates performance measures that institutions can reasonably address, such as the accountability metrics included in H.R. 1201.

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 solve these problems?

As noted earlier, the aging of our population is placing unprecedented demands on the physician workforce. Seniors require more physician visits and a greater range of physician services than any other age group, and these demands will only grow over the next two decades. The nation's medical schools have taken the first step to expand the physician workforce and assure adequate access to care. However, the cap on Medicare support imposed by the Balanced Budget Act of 1997 has prohibited a commensurate growth in the number of residency programs those medical school graduates will need. Additionally, payment reforms have disproportionately affected teaching hospitals, eroding the clinical revenues that also subsidize residency programs. Lifting the cap on Medicare-supported residency positions would enable teaching hospitals that are willing and prepared to train physicians to begin expanding their programs immediately. The legislation described in question #2 (H.R. 1201/H.R. 1180/S. 577) provides a responsible means to achieve these goals and will be critical to prevent disruptions in patient access to care.

Many teaching hospitals also endure numerous administrative burdens in their training efforts, some of which could be resolved through technical fixes. These fixes are summarized briefly below, and the AAMC encourages Congress to advance legislative action on these proposals in addition to the legislation referenced above.

- *Prevent accidental triggering of hospital cap/per resident amount (PRA)*
  Under current Medicare rules, if a non-teaching (community) hospital accepts medical resident "rotators," it risks receiving substantially lower funding from the Medicare program if it ever decides to become a teaching hospital. Specifically, if a community hospital accepts medical residents from a new program at another facility, it risks establishing a very low permanent cap on the number of medical resident slots Medicare will ever fund at the hospital. A hospital that trains rotators from any program also risks establishing a very low PRA, which is the baseline used to determine Medicare DGME payments for teaching hospitals. Some hospitals have not been aware of these risks, and now are unable to build teaching programs. Others that are aware of the risks have decided against hosting rotating residents, even if they have excellent clinical training opportunities available.

- *Eliminate the three year rolling average rules*
  Under current rules, Medicare DGME and IME payments are calculated based on a "three-year rolling average" of the number of medical residents being trained in a given teaching hospital, rather than the current number of medical residents being trained in a given year. Eliminating the rolling average rules would allow a

teaching hospital to be reimbursed for the actual number of trainees in a given year.

- *Count all resident time*
  The Centers for Medicare and Medicaid Services (CMS) requires teaching hospitals to document the amount of time residents spend in each type of training activity (e.g., research-related, certain didactic training) for purposes of calculating Medicare DGME and IME payments. Given that all these training activities are required as part of the medical resident training program, there is little added value in requiring such time accounting, which results in an unnecessary administrative burden.

- *Allow redistribution of closed program residency slots*
  Under current law, if a teaching hospital closes, the slots associated with that hospital are permanently redistributed to other teaching hospitals based on established criteria. However, medical residency slots at a teaching hospital that closes all its training programs, but does not close itself, are not eligible for re-distribution to other facilities. Congress should amend current Medicare rules to allow medical residency slots from hospitals that close all residency programs, but otherwise remain open, to be allocated to other hospitals based on the previously established priorities.

- *Resolve issues with "initial residency period" and residents switching programs*
  Under current law, the length of time Medicare will pay for medical residency training is tied to the expected length of training for a given specialty. Because different specialties have different residency requirements, residents who change specialties, even after one year, often have trouble convincing hospitals to accept them into their programs. The AAMC recommends modifying this policy such that the Medicare "initial residency period" for a resident who changes residency specialties would equal the minimum number of formal training years necessary to satisfy the requirements of the new residency program.

- *Permit new urban teaching hospitals to participate in affiliation agreements*
  Under current law, any urban teaching hospital that began training residents after 1996 may not enter into a Medicare GME affiliation agreement to "loan" its slots to other hospitals. This prevents new urban teaching hospitals from collaborating with community partners. To facilitate such collaboration, CMS should allow new urban teaching hospitals to enter into GME affiliated groups after being a teaching hospital for five years.

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

The AAMC strongly believes that both the state and federal governments must play a significant role in developing the nation's health care workforce. However, because most states must balance their annual budgets, they face unique constraints on spending. This

includes spending on physician training programs, as evidenced by a steady decline in the number of states that provide GME support through their Medicaid programs.

As for the federal role, Congress created the Medicare program to ensure access to health care services for the nation's seniors. From the program's inception in 1965, Congress established reimbursement policy to ensure that total Medicare inpatient reimbursement would be sufficient to enable teaching hospitals to provide the elderly with the range of services that seniors disproportionately need and use. Even when it sought to limit Medicare spending through the institution of a DRG-based inpatient prospective payment system in 1983, Congress called for both DGME and IME adjustments to support access to teaching hospitals. In doing so, Congress also explicitly recognized that its GME adjustments fulfilled Medicare's responsibility as a major insurer of health care to pay its share of the investment needed to secure such access to care.

With less than 1 percent of all physicians in clinical practice formally "opting out" of the Medicare program, the government has a continued responsibility to invest in the infrastructure required to make that insurance coverage meaningful for beneficiaries, including the physician workforce that provides such care. Thus, the AAMC unequivocally believes that preserving Medicare's contributions to physician training is not only appropriate, but also is essential to securing access to high quality health care services for the aging population.

Some stakeholders have characterized the correlation between Medicare discharges and Medicare GME payments as a weakness of the current system. They argue that any setting, including those that do not treat substantial numbers of Medicare patients, should receive the same level of Medicare GME support provided to institutions treating large numbers of seniors. Many low-Medicare settings instead serve high numbers of Medicaid patients. Rather than diverting already limited Medicare GME support to facilities that do not serve high numbers of Medicare beneficiaries, expansion of GME support through state Medicaid programs may be more effective. For example, providing new incentives for states to invest already scarce state dollars in physician training through their Medicaid programs could help bolster support to community health centers, but would not undermine similar investments in facilities serving higher numbers of Medicare beneficiaries.

Another important state-federal partnership that affects the physician workforce is the Conrad 30 J-1 visa waiver program ("Conrad 30"). The federal J-1 "exchange visitor" visa allows medical students from other countries to attend residency training in the United States, requiring physicians to practice for at least two years in their home country after completing their U.S. residency. The Conrad 30 program enables state agencies to recruit these physicians to underserved areas for three years in exchange for waiving the home country practice requirement; the resulting field strength is comparable to NHSC. State agencies have some discretion in shaping their Conrad 30 programs to address states' priorities and some latitude in determining what specialties are needed, provided that they demonstrate, according to their own criteria, shortages in the non-primary care

specialties they recruit. This flexibility in determining what specialties are most needed makes Conrad 30 unique among federal recruitment programs.

Currently, non-primary care specialties constitute approximately half of Conrad 30 waivers requested by state agencies. These requests offer some insights into states' workforce needs, though they may underrepresent the demand for specialists. Many states place limitations on requests to practice in non-primary care specialties, including capping the number of requests or restricting the number of hours practiced in a non-primary care specialty.

As described in question #4, the NHSC State Loan Repayment Program could benefit from similar flexibility in addressing states' varying workforce needs. These recruitment programs are essential and effective tools to help address gaps in the workforce, and they highlight the critical value of state and federal collaborations.