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The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton and Representative Pallone:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to provide comments regarding graduate medical education (GME). The AMA recognizes that, as our nation is working to transform our health care system, there will be necessary changes and improvements to the way we educate our medical students and train our resident physicians. We agree that the existing GME system has created challenges and obstacles for our physician workforce. The AMA is actively working to improve medical education and advanced residency training. However, before seeking wide scale reform of the GME program, the Committee should recognize the reasoning behind the existing GME payment structure and what is working well under the current GME payment system.

While imperfect, GME financing has supported robust medical education and training that is emulated by many other nations and produces the highest-quality physicians. Our nation's public health and economy are linked to the effectiveness and availability of a capable and strong physician workforce. Specifically, residents and teaching hospitals provide a significant source of care for underserved populations, including 40 percent of all charity care in the United States. GME trainees also provide services for the most critically ill patients, including those suffering from HIV/AIDS, burn victims, and veterans, with more than 37,000 residents training at the U.S. Department of Veterans Affairs.

GME is clearly an investment for greater public benefit. To ensure this public good is maintained, lawmakers have recognized that GME must have secure and predictable funding. This is why Medicare has historically played such a fundamental role in financing GME. Moreover, this backbone of support has become even more pivotal as health care undergoes sweeping changes to modernize and develop new payment and delivery models. Indeed, a key conclusion of the Institute of Medicine's (IOM) GME report was the need to ensure sustainability of public GME financing to support the implementation of these changes.

One of our primary concerns is that, at this time of innovation, there are proposals seeking to reduce funding for GME. We believe that decreasing payments to this key public resource would be harmful to patients and would exacerbate existing patient access problems. With these concerns in mind, our comments in response to the Committee's specific requests on GME are provided below. In summary, we believe that the following improvements would help to secure a more stable and effective physician workforce for our nation:

- **Remove the existing arbitrary cap on publically funded residency positions;**
- **Increase the number of GME positions to address future physician workforce, regional, and specialty needs;**
- **Promote educational experiences in the broadest possible range of educational sites, so that residents are experienced in the types of settings in which they may practice after completing GME; and**
- **Actively explore additional sources of GME funding, including states and all-payer models, to ensure adequate and stable support for medical education programs.**

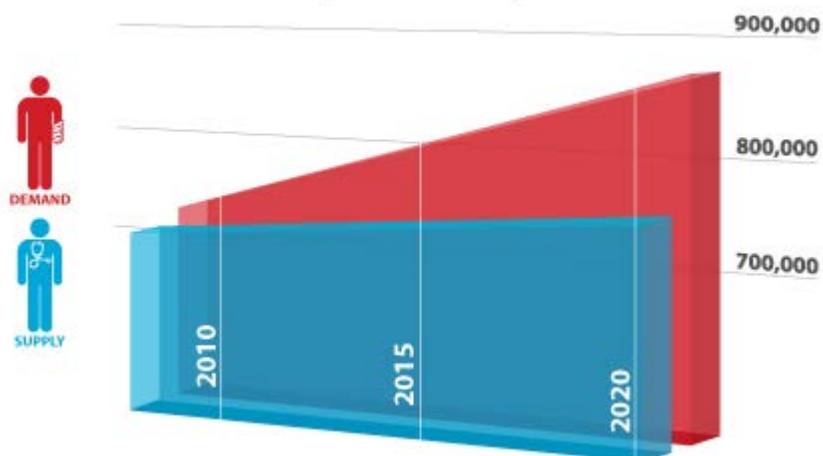
1. What changes to the current GME financing system might be leveraged to improve its efficiency, effectiveness, and stability?

The AMA believes that the current GME financing system is outdated, not transparent, and could benefit from immediate changes. **First and foremost, we believe that the cap on publicly funded GME training slots should be removed.** The existing policy is based on outdated statistics from 1996 and fails to accurately reflect current patient needs, regional demands, and access to certain specialties. Removing this restrictive policy would allow training programs to properly expand or contract over time and enable alignment with patient and population needs as well as changes in local priorities.

GME financing must also reflect the changing health care environment. Estimates of physician workforce shortages have varied but suggest a shortage of approximately 65,800 primary care and 64,800 specialists by 2025.¹

¹ AAMC Physician Shortages to Worsen Without Increases in Residency Training. Available at https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf

Projected Supply and Demand, Physicians, 2008-2020 (ALL SPECIALTIES)



While the IOM debated this projection, demographic data continues to support these figures. The U.S. population has significantly increased over the last several decades, while continuing to grow older. An aging population necessarily increases the demand for physicians, as the elderly are the largest consumers of health care services, being more likely to develop chronic and complex conditions, suffer from heart disease, and develop cancer. America's physicians are also aging, with more than one-quarter likely to retire in the next ten years. Finally, the Affordable Care Act has expanded health coverage to millions of individuals and provides patients with new opportunities to seek important preventive health care services. Even with new innovations such as telemedicine and team-based care models, the growing number of patients signals a real need for more physicians to lead these delivery transformations, oversee teams, and ensure access to care.

The AMA also urges greater alignment between medical school enrollment and available training positions. In the past decade, U.S. medical schools have increased overall enrollment by nearly 28 percent, many in response to concerns about the local physician supply.² The number of international medical students has also grown given the high quality training offered by American residency programs. Yet, residency positions have not kept pace with this increase in applicants. We are concerned that if this trajectory continues, those entering U.S. medical schools will not be able to complete the education and advanced training necessary to become practicing physicians that can improve our nation's health.

² AAMC. 2013 State and Physician Workforce Data Book. Table 10. Available at <https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf>

The AMA also strongly supports innovation in GME and medical education research. The IOM's proposal to pilot new payment models through the Transformation Fund could help drive changes to the current GME system. Yet, we disagree that existing funding should be diverted away from directly supporting training opportunities to operationalize these new programs. Instead, the Committee should consider ways to utilize existing entities, such as the Centers for Medicare & Medicaid Innovation, to test new models. The AMA is also actively engaged in testing and supporting new educational models. Our Accelerating Change in Medical Education³ program has provided over \$11 million in grants to medical schools to develop new models that, once tested, can be adopted more broadly. This program specifically addresses new methods for measuring and assessing key competencies for physicians, promoting exemplary methods to achieve patient safety and patient-centered team care, and optimizing the learning environment. Findings from these models are a valuable resource for the Committee as it considers GME reforms, and the AMA looks forward to continuing this dialogue with the Committee.

2. There have been numerous proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?

The AMA has strongly supported key GME legislation that addresses the changing needs of patients and our health care system. Specifically, the AMA endorsed the Resident Physician Shortage Reduction Act of 2013 (H.R. 1180/S. 577), bicameral legislation that would create 15,000 additional GME positions by 2019. We believe this bill would begin to mitigate the impending physician shortage and would ensure patient access to appropriate care.

The AMA has also offered support for the Creating Access to Residency Education (CARE) Act of 2014 (H.R. 4282), which would authorize \$25 million in grants for new GME positions in states with a low ratio of medical residents. The CARE Act offers a creative solution to GME funding and workforce concerns by establishing federal matching grants, in partnership with other stakeholders, to support new residency positions targeting underserved populations. This bill also ensures stability of funding by requiring those receiving grants to enter multi-year contracts, recognizing that training programs can require up to seven years to complete.

Furthermore, while the AMA did not agree with all aspects of the IOM report, we were encouraged by some of its proposals. In particular, we agree that the residency cap must be lifted, overall GME funding should not be reduced, and innovative payment reforms should be tested and evaluated. We also support innovative pilot programs that promote collaboration with regional providers and payers and that can ensure greater transparency and accountability of GME funding.

³ AMA Accelerating Change in Medical Education. Available at <http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/accelerating-change-in-medical-education.page?>

3. Should federal funding for GME programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

The AMA supports expanding medical residences in a balanced fashion to produce a geographically distributed and appropriately sized physician workforce. To ensure this distribution, GME funding should support a broad range of clinical experiences available in both rural and urban settings. We believe funding for GME should support training of resident physicians in both hospital and ambulatory settings so that residents can learn to practice in a variety of care environments and care for diverse patient populations.

The existing cap on Medicare-funded positions has exacerbated training disparities—freezing both the number and distribution of residency slots without regard for changes in local, regional, or national health care priorities. This is one of the primary reasons why the AMA has called for removal of this outdated approach. **In addition to removing the residency cap, the AMA supports reform that would target new GME funding in areas where there are physician shortages or a low number of medical residents relative to the patient population.** We also support updating accreditation requirements on continuity of care and time spent away from the primary residency site to reduce barriers to rural and other underserved populations.

In addition, the AMA strongly supports loan forgiveness programs, such as the National Health Service Corps, which encourages physicians to train and practice in underserved areas, and the Teaching Health Center program, which would expand residency training in community settings. We urge the Committee to promote these opportunities when considering GME reform so that training settings will more clearly reflect patient care demands.

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

The IOM report recognized the critical role of public funding for GME to ensure a sustainable medical educational system for our nation. The AMA similarly supports maintaining adequate and stable Medicare GME funding, cautioning that limiting this funding could risk serious consequences for patients and the future physician workforce. We therefore agree with the IOM and others who have concluded that Medicare support for GME should not be reduced. In addition, the AMA supports the involvement of other stakeholders in the funding stream of GME to promote community and regional involvement and partnership.

While stakeholders have suggested eliminating the separate funding streams for GME, we caution that this represents a significant change for teaching hospitals that may prove challenging to implement, particularly for large, urban, safety-net institutions. Any changes to the indirect and direct medical education payment streams must be made in a manner that does not adversely affect our nation's safety-net institutions. The AMA believes that a national per-resident-amount (PRA) method of payment could be a more equitable solution in certain circumstances. Such changes could help the development of programs in underserved areas and in ambulatory

settings; however, a wholesale, national rewrite of the current system should not be attempted before being tested and evaluated at a more local level.

We further encourage the Committee to seek funding solutions for the Children's Hospital Graduate Medical Education program (CHGME). Currently, this program relies on annual appropriations that can vary from year to year and offer little stability. We believe a key reform would be to find a more consistent funding stream for CHGME that ensures the viability of this important resource.

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

The AMA supports accountability and transparency in GME funding, but strongly cautions against installing performance-based penalties for GME. Training programs are already extensively evaluated through a comprehensive and thorough accreditation process. Currently, the Accreditation Council for Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) extensively review training programs, using defined standards that require residency programs to provide outcomes evidence and meet guidelines related to specific program requirements. For example, ACGME has developed six core competencies (patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice) and requires programs to regularly assess their trainees' progress in these spheres.

The accreditation bodies are also in the process of modernizing by joining together to create a single accreditation system and focusing more on educational outcomes. In 2013, ACGME began implementing the Next Accreditation System (NAS)⁴ that restructured its accreditation process to focus on educational milestones and specific tasks or activities that residents are expected to achieve as they progress through training (e.g., develop a working diagnosis following a patient encounter). This new system is more transparent by requiring ongoing data collection and trend analysis to ensure that programs meet standards for a safe and effective learning environment. Overall, the AMA believes this enhanced accreditation system can ensure high-quality training programs and accountability without creating new administrative burdens. We urge the Committee to evaluate this new process before devising an alternative system.

Despite these extensive accreditation requirements, stakeholders have suggested implementing accountability programs that essentially duplicate the accreditation process or would require penalties based on performance of students and residents, individuals who are still in the process of learning and improving. We believe such penalty programs are misguided, create additional, unnecessary administrative burdens, and may deter the educational process. Tying financial

⁴ ACGME. Next Accreditation System. Available at <http://www.acgme.org/acgmeweb/tabid/435/ProgramandInstitutionalAccreditation/NextAccreditationSystem.aspx>

outcomes to training is likely to limit educational innovation and result in a teach-to-the-test mentality that is contrary to the high-quality education trainees currently experience during residency and fellowship. Accordingly, we believe these improved accreditation process can be more effectively leveraged to ensure accountability in medical training without the negative consequences of another Medicare penalty program.

6. Is the current system of residency slots appropriately meeting the nation's healthcare needs? If not, please describe any problems and potential solutions necessary to address these problems?

As described previously, we are concerned that our nation's health care system is facing a growing physician shortage and that qualified medical school graduates are unable to enter and complete training, especially in some of the most competitive specialties and regions. Part of this problem is due to the lack of a national workforce policy for physicians and patients. The IOM similarly acknowledged this concern when it tried to estimate the needs of a future physician workforce and recommended developing a GME Policy Council and GME Center. Yet, we are concerned that the IOM's proposed solution, adding two new federal entities, will consume needed resources that could instead be allocated to residency training and add to existing bureaucracy. Ultimately, developing new authorities in an already complex system will inevitably divert funds that could have directly supported needed residency training positions at a time when we need more funding for GME, not less.

Instead of creating new authorities, we urge the Committee to explore new uses of existing entities to move GME forward. Specifically, the Council on Graduate Medical Education (COGME) already has extensive knowledge on GME issues and currently provides recommendations to Congress and federal agencies. It would be less complex and costly to provide additional resources to COGME, including expanding participation of physicians and other health care stakeholders, as opposed to creating new and inexperienced entities. Together with stakeholders, COGME could clarify and strengthen public policy planning and oversight of GME to ensure transparency and better plan for the investment of these funds.

We also urge that the Committee consider fully funding the National Health Care Workforce Commission. This Commission was intended to provide an unbiased source of data on the specialty and geographic distribution of the U.S. physician workforce. Thus far, Congress has failed to appropriate funds that would allow this entity to collect information and provide key analyses to inform future GME decisions.

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

For many years, the AMA has urged that not only states but all relevant payers and stakeholders play a role in funding GME. As discussed previously, the care provided by medical students and residents during and after training is not limited to Medicare beneficiaries but rather impacts all patients. States, localities, and private entities benefit from this care and

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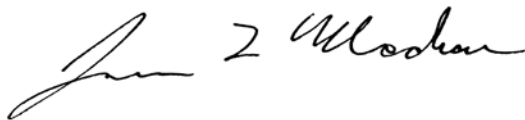
should therefore contribute to its funding. States have played an increasing role in funding GME, and we strongly encourage these initiatives. For example, California recently approved approximately \$7 million in new funding for primacy care residency positions to ensure that its patient population would continue to have access to care.

While we recognize arguments that suggest all-payer models may create instability or variations in the GME funding stream, we argue that, rather than shrinking the funding pie, an all-payer system would expand resources so that all training programs, regardless of location, receive adequate funding. Initially sustaining Medicare funding as the backbone for GME would prevent any early instability of an all-payer model until funding is fully secured and tested successfully on a large scale. We therefore strongly support states' involvement and urge the Committee to more broadly consider the role of other GME payer sources.

Conclusion

The AMA remains committed to supporting GME so that our nation can educate the right number, mix, and distribution of physicians and promote residency training that provides them with the skills to meet the nation's health care needs. In addition to our investment in innovation for medical education, our Council on Medical Education has content expertise spanning the continuum of medical training. The AMA looks forward to sharing the benefits of these resources with the Committee as this important discussion continues. Given the critical importance of GME funding, we hope that the Committee focuses on ways to enhance the quality of medical training while ensuring access to care for patients is preserved. Should you have any questions regarding this letter, please contact Aiken Hackett, Assistant Director, Congressional Affairs, at 202-789-7432 or aiken.hackett@ama-assn.org, or Dana Lichtenberg, Assistant Director, Congressional Affairs, at 202-789-7429 or dana.lichtenberg@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is fluid and cursive, with a large initial "J" and "M".

James L. Madara, MD