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January 16, 2015

The Honorable Joseph R. Pitts
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Re: Graduate Medical Education Open Letter

Dear Chairman Pitts:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) is pleased to respond to your open letter requesting information about graduate medical education (GME). Thank you for seeking our input.

Teaching hospitals train physicians and other health care professionals, offer an environment for conducting biomedical and clinical research, provide highly specialized services, and serve as safety-net providers for the most disadvantaged patients in their communities. Teaching hospitals also prepare physicians for the new demands of a changing health care environment, such as use of health information technology, coordinating care across the continuum, caring for patients in outpatient clinics, and delivering team-based care. As a result, we have the best physician workforce in the world; medical students clamor to receive residency education in the United States.

Congress has long recognized the public good produced by teaching hospitals and has funded GME since the inception of the Medicare program in 1965. Medicare makes two payments with an "education" label – Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) – each of which serves a distinct and often misunderstood purpose. While these payments offer some predictability to teaching hospitals, total GME payments (i.e., DGME plus IME) cover only a portion of the total costs teaching hospitals incur in training residents. Some Medicaid programs and private payers also contribute to the cost of providing GME and teaching hospitals, at times, receive small amounts of funding from other sources.

The AHA believes the current system provides relatively stable, predictable funding for training that is the envy of the world. **We urge the committee to refrain from altering the GME**

financing structure to reduce DGME or IME payments to teaching hospitals. **Rather, we encourage the committee to consider requiring all payers to contribute to GME financing in an effort to provide a more stable environment for physician clinical training.**

In addition, the residency caps, set in 1997, raise the risk of physician shortages and threaten patients' access to care. The purpose and value of GME – assuring an adequate supply of well-trained physicians – will only increase as the U.S. population lives longer with more complex health conditions. **The AHA urges the committee to end the 18-year freeze on the number of physician training positions that Medicare funds and to support the creation of at least 15,000 new residency positions, as proposed in the Resident Physician Shortage Reduction Act introduced by Rep. Joseph Crowley (D-NY) in the 113th Congress.**

Our detailed answers to each of your questions are attached. We look forward to continuing to work with the committee as it reviews GME financing, federal program governance and structure, and how both may be improved or restructured to better meet the country's health professional needs in both the short and long term.

If you have any questions, please feel free to contact me or Priya Bathija, senior associate director, policy, at (202) 626-2678 or pbathija@aha.org or Priscilla Ross, senior associate director, federal relations, at (202) 626-2677 or pross@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President

cc: Members of the Committee on Energy and Commerce

AMERICAN HOSPITAL ASSOCIATION (AHA) RESPONSES TO SPECIFIC QUESTIONS

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

Since the creation of Medicare, Congress has acknowledged the added costs associated with operating teaching programs and recognized the need to support the costs of training residents by directing Medicare to make supplementary payments to hospitals.[1] In the legislative history to the original Medicare legislation, Congress stated:

> Many hospitals engage in substantial education activities, including the training of medical students, internship and residency programs, the training of nurses and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community understands to bear such education costs in some other way, that a part of the net costs of such activities…should be considered as an element in the cost of patient care, to be borne to an appropriate extent, by [Medicare Part A].[2]

Today, Medicare makes two payments with an education label: the Direct Graduate Medical Education (DGME) payment (dating to 1965) and the Indirect Medical Education (IME) payment, which was added to the hospital payment system in 1983. These payments are intended to help cover the costs associated with graduate medical education (GME) programs and support the infrastructure investments, residents' salaries and benefits, and faculty necessary to train the physicians needed today and in the future.

The AHA believes that this financing structure should be maintained in the Medicare program to ensure predictable financing for GME. Medicare GME payments are an integral part of Medicare program entitlement and are largely stable year-over-year, providing a reliable source of funding to hospitals to ensure they can continue educating new residents annually. This is in sharp contrast to the Children's Hospitals Graduate Medical Education (CHGME) Program, which is funded through the annual congressional appropriations process. These yearly appropriations have led to annual debates and unpredictable funding levels for children's hospitals that train residents. Specifically, our data show that since 2009, funding levels for CHGME have generally been decreasing, but have varied anywhere from $317 million to $265 million. Since the training pipeline for physicians can range from three to seven or more years, an annual appropriations process does not provide much-needed stability.

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[1] Tax Equity and Fiscal Responsibility Act of 1982. (Public Law 97-248). http://history.nih.gov/research/downloads/PL97-248.pdf and Social Security Amendments of 1983. (Public Law 98-21). https://www.govtrack.us/congress/bills/98/hr1900/text

[2] S. Rep. N. 404, 89th Cong., 1st Sess. 36 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965).

The AHA urges the committee to consider requiring all payers – in addition to Medicare – (i.e., Medicaid and private payers) to contribute to GME financing. Such a structure could augment existing Medicare funding and ensure predictability. Currently, neither Medicaid programs nor private payers have a statutory federal mandate to support GME. Many states do contribute to GME and private payers may provide higher reimbursement rates to teaching hospitals, but these additional payments vary greatly across states. Teaching hospitals and their ability to support residency training are threatened in a competitive environment and an era of increasingly tight state budgets. The process to train new physicians is long and the risk of not training a sufficient number of individuals is high. Absent GME payments from private payers and consistent GME funding from Medicaid, teaching hospitals are undercompensated for the costs of training physicians. By requiring all payers to contribute explicitly to GME, the committee could provide a broad platform and additional predictability for GME financing.

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?***

Changing health care needs have policymakers focused on revisiting the financing of GME and how physicians are trained. Unfortunately, many of the proposed revisions overlook the rationale for the current GME payment structure and suggest replacing it with new, untested financing models. Many of these proposed changes could threaten the stability of a system that depends upon consistent investment to train physicians over many years. Ultimately, policymakers should ensure that teaching hospitals continue to have the financial support necessary to continue training talented and diverse physicians.

Some policymakers have advocated ways to ease the cap on the number of training positions that Medicare will support. The current cap on residency slots was set in the Balanced Budget Act of 1997 and restricts the number of residency slots for which hospitals may receive Medicare DGME funding. A cap also limits the number of residents that hospitals may include in their ratios of residents-to-beds, which affects IME payments.

Several bills considered by the 113th Congress have received bipartisan support and would have increased the number of residency positions. For example, the AHA strongly supported the Resident Physician Shortage Reduction Act, introduced in March 2013 by Sens. Bill Nelson (D-FL) and Chuck Schumer (D-NY), and a companion bill by Rep. Joseph Crowley (D-NY) to add 15,000 residency slots by 2019.[3] The legislation outlined a hierarchy for distributing the new slots, prioritizing teaching hospitals that opened on or after Jan. 1, 2000, currently have more residents than their Medicare-funded slots, and/or train physicians in community or outpatient settings. At least half of the new slots would be for specialty residency programs with shortages, as determined by the Health Research Services Administration (HRSA). **The AHA urges the committee to end the 18-year freeze on the number of physician training positions that**

[3] S.577 and H.R.1180 Resident Physician Shortage Reduction Act of 2013. (14 March 2013). https://www.congress.gov/bill/113th-congress/senate-bill/577/text

Medicare funds and to support the creation of at least 15,000 new residency positions, as included in this legislation.

Other proposals to reform GME would not increase residency slots but focus instead on altering Medicare's GME financing structure and, in some cases, propose reducing GME payments to hospitals. **The AHA opposes proposals that would alter the GME financing structure in a way that will reduce DGME or IME payments to teaching hospitals. Reductions in Medicare financing for medical education would threaten the stability and predictability teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.**

Most recently, the Institute of Medicine (IOM) report published in July 2014 recommended sweeping changes to Medicare's GME financing structure. The IOM recommended maintaining the total level of GME funding, but phasing out the distinction between DGME and IME in favor of a single GME payment based on a per-resident amount, adjusted geographically. The IOM proposal would end the stable financing mechanism, uncouple Medicare GME payments from Medicare volumes and permit funds designated for teaching hospitals to be paid to other entities that do not treat Medicare patients.

Further, the IOM recommends moving to a performance-based system of financing by dividing the total GME budget (i.e., payments previously allocated across DGME and IME) into two subsidiary funds. The Operational Fund would finance ongoing residency programs and the Transformational Fund would support the development of innovative programs. Over five years, IOM estimates that these changes would reduce GME payments to existing teaching hospitals by more than 35 percent – a draconian reduction. In addition, the IOM recommends re-evaluating the need for continued Medicare funding of GME after 10 years.

Beyond recommending extreme changes to the GME financing structure, the IOM did not support an increase in residency slots because it presumes that new models of care delivery will utilize non-physician clinicians and, thus, alleviate any physician shortages. However, the annual physician survey by Merritt Hawkins found that "protracted wait times persist[ed]" in 2013 despite the increasing prevalence of physician assistants and nurse practitioners in practice workflows.[4] Two trends exacerbating physician shortages are the increasing number of individuals with insurance coverage due the Affordable Care Act (ACA) and the aging population. Recent estimates by HRSA show the U.S. will need from 6,400 to 20,200 additional

[4] Miller P. (2014). Merritt Hawkins. Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates. http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf

primary care physicians by 2020.[5] The Association of American Medical Colleges (AAMC) predicts a deficit of 45,400 primary care physicians because of coverage expansion by FY 2025.[6]

Taken together, IOM's recommended GME payment redistribution and dismissal of evidence indicating a looming physician shortage would not only negatively affect teaching hospitals, but also potentially create physician vacancies in community hospitals, particularly in rural areas. These effects could ultimately restrict patient access to care.

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

Federal funding for GME programs should ensure training opportunities are available in both rural and urban areas. The shortage of physicians in rural areas has spurred teaching hospitals to offer rural residency programs. Congress formally created the phrase "Medicare Rural Training Track" (RTT) in 1999, but teaching hospitals had offered rural-focused tracks previously. The RTT offers additional funding support for teaching hospitals offering rural-focused tracks.

The University of Washington School of Medicine has led a regional medical education consortium since the early 1970s to train primary care physicians from the states of Washington, Wyoming, Alaska, Montana and Idaho.[7] Known by the acronym WWAMI, the consortium rotates physicians through a variety of settings, particularly in underserved and rural areas. In accredited RTT residencies, physicians work in an urban area for one year and then transfer to a rural setting for two additional years of training.

The effect of RTTs is lasting. For example, more than 57 percent of students who completed the University of Missouri's RTT went on to practice in a rural location.[8] Today, there are 29 RTTs with an additional seven like RTTs active in 24 states.[9]

Medicare policy on GME encourages training in rural areas. Critical Access Hospitals (CAHs) that train residents are reimbursed at 101 percent of their reasonable costs and are not subject to

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[5] Health Resources and Services Administration. (November 2013). Projecting the Supply and Demand for Primary Care Practitioners Through 2020. http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf

[6] Association of American Medical Colleges. (June 2010). The Impact of Health Care Reform on the Future Supply and Demand for Physicians Updated Projections Through 2025. Workforce Studies. https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf

[7] University of Washington Medicine. (6 November 2014). WWAMI. http://www.uwmedicine.org/education/wwami

[8] Quinn KJ, et al. (November 2011). Influencing Residency Choice and Practice Location Through a Longitudinal Rural Pipeline Program. Rural Medical Education. http://www.ncbi.nlm.nih.gov/pubmed/21952065

[9] Train Rural. (2014). Directory of Rural Programs. http://www.traindocsrural.org/rural-residency/directory-of-rural-programs/. Teaching hospitals that do not have the required RTT accreditation for their residency program, but offer at least 24-months of training in a rural clinic or family practice site, as required by ACGME, are considered "like" RTTs.

the residency caps, while other teaching hospitals receive the DGME and IME payments discussed above that cover only a fraction of the institution's actual direct costs. The Medicare program also allows rural hospitals to expand their caps for the purposes of adding new residency programs, while Medicare support for other hospital teaching programs is limited by residency caps.

The reality, however, is that the cost of starting a GME program is substantial. Medicare pays only a portion of these costs, in the best of circumstances. It also is difficult to sustain GME over multiple years in rural areas because rural hospitals rely heavily on Medicare and Medicaid payments, which do not cover the total cost of care (i.e., rural hospitals often have a payer mix with higher percentages of Medicare and Medicaid patients and lower percentages of private pay patients). Also, while there is some correlation between where a resident trains and where he/she chooses to practice, attracting physicians to rural areas is a complex undertaking. GME financing may be only one step and other options, including financial incentives or loan forgiveness programs for new physicians, should be considered.

We urge the committee to continue federal support for these programs to ensure training opportunities are available in rural areas. Additional reforms in this area should be directed at improving the many challenges rural hospitals continue to face related to GME, including sustainable financing, recruitment of both residents and faculty, and academic recognition and support. We also urge the committee to consider other types of incentives to attract physicians to practice in rural settings.

4. ***Is the current financing structure for GME appropriate to meet current and future healthcare workforce needs?***
    - ***i. Should it account for direct and indirect costs as separate payments?***
        - ***a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?***
        - ***b. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsible to current and future workforce needs?***
    - ***ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?***

The AHA believes that the current financing structure for GME is appropriate to meet today's and future health care workforce needs and should continue to account for direct and indirect costs separately. As currently structured, Medicare makes two payments with an "education" label – DGME and IME – and the Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs for training physicians.

Each of these payments serves a distinct purpose. DGME payments help fund the direct costs of operating residency programs, such as resident stipends and benefits, faculty salaries and benefits, and administrative overhead expenses such as classroom space. Medicare DGME payments are based on a hospital-specific, per-resident cost determined in 1984 and updated

annually for inflation. Medicare makes DGME payments to each hospital based on its Medicare share of total inpatient days. Teaching settings other than hospitals, such as community health centers, also can receive DGME payments.

The purpose of IME payments is often misunderstood. IME payments are *patient care payments* explicitly made to compensate for the higher operating costs associated with teaching hospitals, such as treating complex, severely ill patients, residents' "learning by doing" and greater use of emerging technology. Teaching hospitals offer specialized and often unique services, such as trauma centers and burn units, that can contribute to higher operating costs. The IME payment adjustment is a percentage add-on to the hospital's inpatient prospective payment system, and varies based on the intensity of the hospital's teaching programs as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio is capped at 1996 levels.

Congress recognized the need for the IME adjustment at the inception of the inpatient prospective payment system in 1983:

> 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 (*emphasis added)*.[10]

In 1999, Congress restated the need for IME "...to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals."[11]

Proposals to restructure GME funds to "follow the resident" are ill-advised. Teaching hospitals provide significant infrastructure for operating training programs, often multiple programs. GME funding should be provided to the entity that incurs the cost of training.

Medicare DGME and IME payments are not sufficient to fully fund the costs teaching hospitals incur in training residents. Teaching hospitals incur approximately $100,000 per year in direct training costs for each resident, but receive an average of $40,000 in DGME payments from Medicare.[12] The AAMC also estimated that teaching hospitals' mission-related

[10] House Ways & Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report No. 98-23, March 11, 1983.
[11] U.S. Congress, House of Representatives, Committee on Ways and Means. Medicare and Health Care Chartbook. May 17, 1999 Washington, DC U.S. Government Printing Office.
[12] Paz HL. (November 2011). Funding for Medical Education Under Fire. Penn State Milton S. Hershey Medical Center College of Medicine. *Perspectives*. http://www.libraries.psu.edu/psul/hershey/about/ceo-perspectives/funding-for-medicaleducationunderfire.html

costs exceed total IME payments.[13] Even if IME compensated teaching hospitals for training residents, rather than mission-related costs, total DGME and IME payments are still insufficient to cover the cost of training. For example, after accounting for total DGME and IME payments, family medicine residencies at teaching hospitals in Washington, Wyoming, Alaska, Montana and Idaho still had an average shortfall of over $27,200 per resident.[14]

It does not appear that the financing structure of GME affects the availability of specialty and primary care physicians. There is ample evidence that factors other than GME financing are influencing the medical students' choice of specialty. For example, reimbursement levels may provide much more powerful incentives. As MedPAC indicated in its June 2010 report to Congress, the "single most important way Medicare can influence the mix of physicians … is to reform how it pays for services."

Teaching hospitals have responded to new payment and delivery models that emphasize primary care to improve patient outcomes and reduce costs, and have created ambulatory residency rotations to address the current primary care shortage. These rotations combine inpatient and outpatient clinic training to prepare well-rounded general internists and other specialists to serve the estimated 62 million Americans who have limited to no access to primary care physicians.[15] For example, the University of Cincinnati College of Medicine has pioneered this approach with an ambulatory residency rotation called "long block" that immerses residents in the patient-centered medical home (PCMH) model for an entire year.[16] Over the past five years, many more teaching hospitals have embraced longer rotations in outpatient clinics to train residents in the provision of ambulatory care.[17]

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 United States can be proud of a highly competent physician workforce. There is no need for Congress or the federal government to reform training programs when private-sector initiatives are working to ensure production of a well-trained physician workforce.

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[13] Association of American Medical Colleges. (2014). What Does Medicare Have to Do with Graduate Medical Education? https://www.aamc.org/advocacy/campaigns_and_coalitions/gmefunding/factsheets/253372/medicare-gme.html

[14] Lesko S., et al. (September 2011). Ten-Year Trends in the Financing of Family Medicine Training Programs. *Family Medicine.* http://mail.fmdrl.org/fmhub/fm2011/September/Sarah543.pdf

[15] National Association of Community Health Centers. (March 2014). Access Is the Answer: Community Health Centers, Primary Care & the Future of American Health Care. http://www.nachc.com/client/PIBrief14.pdf

[16] PCMHs are specialty or primary care practices that provide accessible, continuous, comprehensive, and coordinated care. PCMH providers engage patients in shared decision-making, offer extended hours, communicate electronically, and coordinate with the range of providers seen by their patients. Dardani W and Lyles M. (November 2010). Moving the Medical Home Forward: Innovations in Primary Care Training and Delivery. Association of American Medical Colleges. http://www.ucdmc.ucdavis.edu/internalmedicine/newsroom/teach_aamc.pdf

[17] Colbert JA. (8 August 2013). Experiments in Continuity—Rethinking Residency Training in Ambulatory Care. New England Journal of Medicine. http://www.nejm.org/doi/full/10.1056/NEJMp1301604

The Accreditation Council for Graduate Medical Education (ACGME), which accredits 9,500 residency programs, is already ensuring development of a competent physician workforce for the future. The accreditation process has evolved to include competency-based education and the ACGME effectively sets educational standards to ensure consistent resident training curricula at each institution.[18] These standards continually evolve to incorporate emerging changes in health care.

A survey conducted by the AHA in 2011 found that new physicians needed additional training in the areas of communication, use of systems-based practices, and interprofessional teamwork, and highlighted the need to educate U.S. physicians, residents and fellows to address quality improvement.[19] The ACGME, recognizing the public's need for a physician workforce capable of meeting these and other requirements of the changing health care environment, has implemented the Next Accreditation System (NAS).

The NAS emphasizes outcomes of resident and fellow learning, assessed through a set of performance measures, including the Milestones Project, which indicate the individual's progress toward independent practice.[20] The Milestones Project sets measureable targets at each stage of medical education. These targets encompass core skills including participation in new care delivery models, such as team-based care, achieving high care quality and ensuring patient safety. Teaching hospitals must submit reports on these measures every six months to maintain accreditation.[21] The Milestones Project has received support from AHA, AAMC and the American Medical Association. Further, ACGME is collaborating with the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine to create a single accreditation system for all U.S. GME programs.[22]

More recently, the ACGME has established another component of NAS, the Clinical Learning Environment Review (CLER) program. The CLER program is designed to provide teaching hospitals, medical centers, health systems and other clinical settings affiliated with ACGME-accredited institutions with periodic feedback that addresses the following six areas: patient safety; health care quality; care transitions; supervision; duty hours and fatigue management and

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[18] Accreditation Council for Graduate Medical Education. (6 November 2014). About ACGME. https://www.acgme.org/acgmeweb/tabid/116/About.aspx.

[19] Combes JR, Arespacochaga e. American Hospital Association Physician Leadership Forum. Lifelong Learning: Physician Competency Development. Chicago, Il: American Hospital Association; June 2012. file:///Users/pjbathija/Downloads/physician-competency-development.pdf

[20] Accreditation Council for Graduate Medical Education: CLER Pathways to Excellence: Expectations for an optimal clinical learning environment to achieve safe and high quality patient care. http://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf.

[21] American Council on Graduate Medical Education. (August 2014). Milestones: Frequently Asked Questions. http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/MilestonesFAQ.pdf; American Council on Graduate Medical Education. (23 July 2014). Milestones by Reporting Date. http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/MilestonesByReportingDate.pdf

[22] American Council on Graduate Medical Education. (19 July 2014). Press Release: ACGME, AOA, AACOM Single GME Accreditation System. https://www.acgme.org/acgmeweb/Portals/0/PDFs/Nasca-Community/AOA_letter_to_the_Community.pdf

mitigation; and professionalism.[23] Through this program, the ACGME will generate national data that will show a continuum of progress toward achieving optimal resident and fellow engagement in each of these six areas.

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

The current limit on Medicare financing of residency slots, set in 1997, is not appropriately meeting the nation's health care needs and must be lifted in a thoughtful manner. As indicated above, the AHA urges the committee to end the 18-year freeze on the number of physician training positions that Medicare funds and support the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots).

In the Balanced Budget Act of 1997, Congress imposed residency caps for the first time to control Medicare spending on GME. These caps restrict the number of residency slots for which hospitals may receive Medicare DGME funding and limit the number of residents that hospitals may include in their ratios of residents-to-beds, which affects IME payments. The caps are hospital-specific, meaning that a hospital cannot expand Medicare-funded slots in one residency program without corresponding reductions in another.[24]

Since the caps took effect, the number of first-year residency slots has grown slowly, with growth primarily driven by hospitals self-funding new slots.[25] The total number of Medicare and self-funded slots grew from over 20,200 in 1997 to 26,600 in 2014, a compound annual growth rate of only about 1.6 percent.[26] During that same period, the number of U.S. and international applicants for first-year residencies increased at a compound annual growth rate of nearly 5.7 percent.[27]

In 2014, more than 1,100 teaching hospitals offered approximately 26,600 first-year residency slots in the National Resident Matching Program (the Match), including 9,500 through the Veterans Health Administration.[28] While the total number of residency slots exceeds the number

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[23] Accreditation Council for Graduate Medical Education: CLER Pathways to Excellence: Expectations for an optimal clinical learning environment to achieve safe and high quality patient care. http://www.acgme.org/acgmeweb/Portals/0/PDFs/CLER/CLER_Brochure.pdf

[24] England C. (August 2013). Raising the Residency Cap. Chicago Medical Society. http://www.cmsdocs.org/news-publications/chicago-medicine-magazine/2013-issues/August2013Issue.pdf

[25] Harwood JL and Pugely AJ. (September 2014). The Evolution of GME Funding: U.S. Healthcare Workforce Reaches a Crossroads. *AAOS Now*. http://www.aaos.org/news/aaosnow/sep14/advocacy3.asp

[26] Avalere analysis of National Resident Matching Program data from 1997 to 2014.

[27] Ibid.

[28] Centers for Medicare & Medicaid Services. (1 October 2013). Open Payments: List of Teaching Hospitals. http://www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/2014-Open-Payments-Cycle-Teaching-Hospital-List-[October-2013].pdf; National Resident Matching Program. (April 2014). Results and Data: 2014 Main Residency Match. http://www.nrmp.org/wp-content/uploads/2014/04/Main-Match-Results-and-Data-2014.pdf; Association of American Medical Colleges.

of U.S. medical school graduates annually, these individuals must also compete with graduates from prior years who did not get placed in residency programs during the previous year, as well as graduates of international medical schools (i.e., U.S. and non-U.S. citizens) seeking U.S.-based residency training. Across these three groups, more than 34,200 graduates applied for residency positions in 2014, resulting in a shortfall of nearly 7,600 positions.[29] The shortfall is particularly high for certain specialties. For example, in 2014there were 4,700 more applicants than there were available Internal Medicine residency slots.[30]

Despite these shortfalls, Congress has made only marginal changes to address the shortage in residency slots in certain areas since 1997. For example, in 2003, the Medicare Prescription Drug, Improvement, and Modernization Act reduced the number of residency slots for hospitals that were not filling their slots, and redistributed them to other hospitals. Similarly, the ACA also provided for the redistribution of "unused" full-time employee (FTE) slots and provided for the permanent redistribution of FTE slots from closed hospitals.

While these changes allowed for redistribution of slots, Congress has not eased the 1997 caps on Medicare-funded residency positions. Holding the number of total residency slots constant could create significant access challenges, especially as the number of individuals with insurance increases under ACA coverage provisions. The aging population worsens this issue, since older Americans have much higher physician utilization and often rely heavily on specialists, many of whom are in shortage today. These shortages are expected to increase with current estimates ranging from 46,100 to 62,400 additional specialists needed by 2020.[31]

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

The AHA believes that both state and federal government should play a role in developing our nation's health care workforce. Unlike Medicare, the federal government does not require state Medicaid programs to support GME, although most states do. Currently, 42 states and the District of Columbia provide Medicaid GME payments, but every state has contributed at some point in the past.[32] States that ended their contributions did so due to increased budgetary pressures. For those states that still pay for Medicaid GME, their reimbursement mechanisms vary widely – from additional per-case payments on top of fee-for-service rates to a lump sum payment based on the hospital's total share of Medicaid revenue or patient volumes.[33]

(September 2014). VA Graduate Medical Education.
https://www.aamc.org/advocacy/budget/va/74964/va_gme.html
[29] National Resident Matching Program. (April 2014). Results and Data: 2014 Main Residency Match.
http://www.nrmp.org/wp-content/uploads/2014/04/Main-Match-Results-and-Data-2014.pdf
[30] Ibid.
[31] Colbert JA. (8 August 2013). Experiments in Continuity—Rethinking Residency Training in Ambulatory Care. New England Journal of Medicine. http://www.nejm.org/doi/full/10.1056/NEJMp1301604; Health Resources and Services Administration. (December 2008). The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf
[32] Association of American Medical Colleges. (2013). Medicaid Graduate Medical Education Payments: A 50-State Survey 2013.
[33] Ibid.

As a result, Medicaid funding for GME can be highly variable and inconsistent from year to year. **The AHA urges the committee to consider requiring state Medicaid programs to contribute to funding GME.** As discussed above with the all-payer funding of GME, this change could be integrated into the existing infrastructure, augment current Medicare funding for GME and ensure predictability in GME funding.