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**Comments of  
The Association of American Medical Colleges (AAMC)  
to the  
Chairmen, House Committees on Ways and Means, Energy and Commerce, and Education  
and Labor**

**“Text of the House Tri-Committee Health Reform Discussion Draft”**

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**Introduction**

The Association of American Medical Colleges (AAMC) thanks the Chairmen for the opportunity to comment on their draft health care reform legislation & supports the bill’s intent to expand coverage while improving delivery throughout the US health care system.

The AAMC is a not-for-profit association representing all 131 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians. The AAMC and its members are committed to improving the nation's health through medical education, research, and high-quality patient care. Together, our members provide approximately one-fifth of all clinical care in the country and over forty percent of hospital charity care.

The nation’s teaching hospitals and medical schools applaud the Committees for their efforts to craft comprehensive health care reform legislation to improve the nation’s health. We are pleased to see that the objectives align closely with those of the AAMC, namely:

- Ensuring that affordable, transportable, and continuous health care coverage is available to all;
- Rethinking the delivery system to facilitate health promotion and disease prevention while providing high-quality, cost-effective care;
- Creating financing mechanisms that are sustainable, equitable, explicit, and accountable while promoting quality;

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- Preserving the safety net for vulnerable populations until new alternatives are proven to be superior;
- Ensuring an adequate supply of health care practitioners that reflect the nation and its health care needs; and
- Continuing to advance discovery and innovation to support research and a “learning” health care system.

The AAMC hopes the Committees will incorporate the following comments as they move forward in drafting specific policy proposals. Our comments reflect perspectives from our broad membership of physicians, hospitals, medical researchers, and the educators of the next generation of health professionals. We look forward to working with you and other policymakers to ensure the best policies to achieve better health for the nation are enacted.

We have offered suggestions for clarifications and edits to the draft language in an attempt to be as helpful as possible and welcome further opportunities for dialogue with Committee staff at any time.

### **Title V—Medicare Graduate Medical Education (GME)**

We applaud the recognition that the health care workforce must be expanded to address current physician shortages, particularly if coverage is expanded to currently uninsured Americans. The proposed redistribution of unused Medicare-supported Graduate Medical Education (GME) training slots represents a small first step in increasing physician supply. However, the proposed redistribution is unlikely to produce more than a few hundred additional physicians annually, and falls short of what is needed to address a projected shortage of over 100,000 physicians in multiple specialties.

A major concern of the academic community remains that, while there is a clear shortage of primary care physicians nationally, individual communities reflect the fact that all health care—and workforce—is local. **Teaching hospitals and medical schools must have the flexibility to train physicians based upon population needs and often this is not limited to primary care.**

The number of general surgeons in the United States has decreased by 26 percent since 1981; numerous specialties that primarily serve the elderly, such as cardiology, oncology, and geriatrics have projected significant shortages in the coming decade, which if unaddressed, will lead to decreased access and potentially higher costs. The nation also has shortages of pediatric subspecialists. These shortages will be particularly severe in rural communities and further disadvantage underserved communities.

**The AAMC strongly urges the House to include in any health reform legislation the language included in the AAMC-supported GME language included in bills introduced by Reps. Crowley and Schwartz (H.R. 2251 & 2350).** The language makes a more comprehensive and significant investment in physician training by adding 15 percent more Medicare-funded GME positions. Since the Balanced Budget Act of 1997, Medicare has been severely restricted in the level of support it can provide for physician training and the unique clinical training

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environment maintained by teaching hospitals. This, in no small part, has contributed to physician shortages across the nation, particularly in primary care.

The AAMC applauds the Chairmen's recognition of, and proposals to address, the many regulatory barriers to placing residents in non-hospital locations for portions of their training. Provisions in H.R. 2251 & 2350 similarly address these issues.

If the Office of the Inspector General is to be tasked with a report under Sec 1502 to assess the impact of these provisions on training in outpatient settings, the AAMC strongly suggests that the report include an assessment of the effect on primary care workforce development of the multiple components of the GME section devoted to increasing primary care training. **In particular, the report should include an assessment of the ability of primary care training programs to fill their respective additional residency positions disseminated through the redistribution with special attention to whether physicians entering those training positions are US MDs, DOs, or International Medical Graduates (IMG); and whether those positions are able to be filled through the NRMP process or must be filled outside of the traditional 'Match'.**

**Sec 1502 (d) ("DEMONSTRATION PROJECT FOR APPROVED TEACHING HEALTH CENTERS") is both unnecessary under current law and ignores the purpose of Medicare's support for Direct GME costs.**

The Balanced Budget Act of 1997 included a provision permitting the Secretary of Health and Human Services to make Medicare payments directly to "qualified nonhospital providers" that incur direct teaching costs in the operation of an approved medical residency training program. Prior to this legislation, only hospitals could receive Medicare teaching payments for residents training in nonhospital sites. The BBA states that the definition of a qualified nonhospital provider must include Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Medicare + Choice organizations and "other such entities as the Secretary deems to be appropriate."

The July 31, 1998 Final Rule designates FQHCs, RHCs and Medicare + Choice entities as "qualified nonhospital providers" that are eligible to receive direct teaching payments. HCFA made these payments effective for portions of cost reporting periods occurring on or after January 1, 1999. The payments are made only if the nonhospital provider incurs "all or substantially all" of the costs of the training program in the nonhospital setting. The definition of "all or substantially all" is the same as used for determining when a hospital is eligible for payment.

For FQHCs and RHCs (42 C.F.R. 405.2468(f)(6)) three types of direct costs are reimbursable:

1. Residents' salaries and fringe benefits (including travel and lodging expenses where applicable)

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2. The portion of teaching physician salaries and fringe benefits related to the time spent in teaching and supervising residents. These costs include time spent developing in resident schedules and evaluating residents.

3. Facility overhead costs that are allocated to direct GME. These costs include only those that are allocable to direct GME and that are not incurred in patient care. For example, a teaching physician's office costs allocated to GME, or a conference room dedicated specifically for resident training, would be considered direct teaching costs. However, new patient care rooms would not be considered direct GME costs.

Payment amount for these costs are equal to the product of the these costs and Medicare's share, defined as the ratio of Medicare visits to total visits.

is cost-based reimbursement for resident and supervisory costs as well as GME overhead costs. These costs would be subject to Medicare's reasonable cost principles (42 C.F.R. Part 413) and Reasonable Compensation Equivalency Limits (42 C.F.R. 415.60 and 415.70).

All of these existing provisions are consistent with Medicare's support for Direct GME costs and are predicated on the intent that the Medicare program should pay its share—determined by the share of Medicare discharges—of the costs of training residents. **Diverting payments intended to support Medicare's share of training costs to sites which typically provide care to very few Medicare beneficiaries makes little sense and is inconsistent with the program's original intent.**

If Congress intends to further support the efforts of training within CHCs, an alternative would be to authorize the HHS Secretary to award grants through the CHC program for the activities the demo project would support. This could be achieved through Section 330 of the PHSA (42 USC 254b) inserting between (j) and (k) (and re-designating everything following as needed):

“(k) Graduate Medical Education Activities

(1) In General – The Secretary may award grants to a health center that develops and operates an accredited primary care residency program to provide for the center's costs of graduate medical education activities for primary care residents.

(2) Eligible health center – For the purposes of this subsection, entities eligible for such grants means an entity that –

(A) Is a health center as defined under subsection (a) of this section;

(B) Develops and operates an accredited primary care residency program; and,

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(C) Submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) Use of Funds – INSERT USE OF FUNDS HERE.”

With regard to **Sec. 1505, “Improving Accountability for Approved Medical Residency Training.”** the AAMC understands the need to identify and reinforce competencies of GME training already put in place by the Accreditation Council on Graduate Medical Education (ACGME) and **offers the following revisions to 1505(a):**

*“IN GENERAL - Teaching hospitals and training programs shall continue to teach future physicians the skill-sets necessary to meet the health needs of our society while improving quality and performance.*

*Amend 1886(h)(5)(A) to say: “Hospitals with approved medical residency training programs, as defined in paragraph (5), shall continue to be accountable for ensuring that residents are trained in systems-based practice, including:*

- i) experience in settings and systems relevant to their clinical practice*
- ii) experience in the coordination of patient care across settings relevant to their specialties*
- iii) an understanding of the relevant cost and value of various diagnostic and treatment options*
- iv) experience in inter-professional and multi-disciplinary care teams*
- v) experience in the use of health information technology to identify system errors and to improve the quality of care.”*

The AAMC understands, similarly, the provisions of 1505(b) (1) (A) which would require the Government Accountability Office to report on the current status of training programs in achieving such goals; the GAO should be instructed to work with the ACGME to ensure such information is reported in the context of the goals of medical education.

**The AAMC strongly opposes the 1505(b)(1)(B) & (b) (2) which would require the GAO to assess faculty expertise; develop curricular requirements; and assess the accreditation processes of the ACGME.** All three of these activities fall far beyond the expertise and capabilities of the GAO and must remain within the purview of educational accreditation bodies whose expertise and processes are not likely to be benefited from GAO review.

#### **SEC. 1844. PAYMENTS FOR GRADUATE MEDICAL EDUCATION.**

The AAMC appreciates the willingness of the Chairmen to clearly establish in statute the right of states to cover expenses related to GME through the Medicaid program. Forty-seven states and

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the District of Columbia already make such payments and this policy has been in place for over 40 years. We do wish to note, however, that collection of further information at the state and local level about Medicaid GME payment policy should, in no way, be evaluated by the proposed national workforce commission. States' workforce needs—and those of local communities—differ across the nation, and Federal workforce mandates through the Medicaid program are both unwarranted and potentially harmful to local communities whose health care needs may differ significantly from the national aggregate.

### **Sec 1112 & Sec 1804: Medicare & Medicaid DSH Reports**

The AAMC applauds the Chairmen's recognition that any improvements to coverage, payment, and access will need to be assessed in a thorough and ongoing fashion. We believe that the draft language's current approach (mandating a report in 2016) will help to minimize the unintended consequences of altering DSH policy for both patients and providers.

### **Physician Payment Policy**

#### **SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.**

**The AAMC supports a full repeal of the sustainable growth rate (SGR) and applauds the reforms in the bill as the first steps toward comprehensive reform.** We favor using the Medicare Economic Index (MEI) to update physician services for 2010, thereby preventing a negative 21 percent update from taking effect. We also support rebasing the SGR by using 2009 actual expenditures and ensuring that expenditures are never more than five years old.

The AAMC is pleased that the bill definition of "evaluation and management" (E&M) service category includes a variety of cognitive services, including consultations and office visits to specialists.

The bill specifies a separate growth rate for calculating updates to each of the proposed service category conversion factors (2% growth rate for E&M services and 1% growth for all other services.) This growth rate differential appears to support the policy goal of increasing primary care services. **The AAMC suggests that the bill include language requiring CMS to study the impact of the new update methodology.** The study should evaluate the methodology for determining updates; determine whether the 1% and 2% updates are appropriate; and examine whether changes should be made in the service categories, such as the need to establish additional categories.

#### **SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.**

The AAMC supports accurate payment for physicians and funding to ensure the codes in the physician fee schedule are valued correctly. We agree that both under-valued and overvalued codes should be reviewed, and that work evaluation needs to consider mental effort and technical skill, as well as time.

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With the funding allotment, CMS should consider a study measuring the effort and time involved with teaching residents and medical students and whether teaching physicians should receive special payments for this service.

### **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS**

**The AAMC strongly opposes the bonus payments for “efficient areas.”** CMS has stated “value” incorporates quality as well as utilization; however this bonus only rewards low-utilization which may reflect only errors of omission in the care of patients. While geographic variations in services are real, the reasons for variation are still not clear. There are clear concerns about basing policy on the current data that is available. This requirement also conflicts with the Civil Monetary Penalty law that imposes penalties “if a hospital or a critical access hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to **reduce or limit services.**” The OIG’s expansive view regarding the reach of this statute would pose an impediment to rewarding reduced utilization.

### **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI).**

The AAMC supports the following elements in this section:

- Providing timely feedback reports to eligible professionals;
- Implementing an appeals process for eligible professionals; and
- Extending incentive payments through 2012.

The AAMC also supports integrating the physician reporting with the definition of meaningful use of electronic health records; however, we are concerned about the timing of the proposed plan to do this. The proposed legislation requires CMS to have a plan by January 1, 2012. This date does not provide adequate time for CMS to learn the issues and difficulties that professionals may encounter in EHR implementation, because the first HIT incentives associated with ARRA will not be distributed until 2012. In addition, CMS is still learning how to accept quality data from electronic health records. Currently PQRI does not have any reporting through EHRs, although CMS is testing data submission with 10 measures. These 10 measures are not relevant to all specialties, but the 153 measures and 7 measure groups in the 2009 PQRI offer professionals more options for reporting. Time is necessary in order to ensure a thoughtful transition so that all specialties can submit meaningful measures.

### **SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.**

The AAMC supports the extension of the geographic floor for work relative value units through 2012.

### **Section 1301: Accountable Care Organization Pilot Program**

We applaud the inclusion of a pilot program to test new delivery models, however we believe such a program must allow hospitals and hospital systems to participate and be included in the definition of accountable care organizations. While the AAMC supports the concept of

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Accountable Care Organizations, current language should include the option for hospitals to directly participate in any pilot programs.

To date, most demonstration efforts that have examined ways to decrease costs while improving quality have been constrained by their narrow focus on distinct populations and discrete diagnostic-related groups, rather than the broad continuum of care (a continuum encompassing the full range of prevention, primary care, specialty services, inpatient care, post-acute and sub-acute care, home care, and rehabilitative services). The narrow focus of these earlier demonstration projects has made it difficult to calculate the potential savings of new models of care and to extrapolate the knowledge gained to other populations.

There is a clear need for much more broadly-based regional demonstration projects that encompass broad patient populations and tertiary/quaternary care organizations and that facilitate greater provider integration, the redesign of inpatient, ambulatory, and post-acute care, and the testing of new payment methodologies. To achieve these goals, existing legal and regulatory impediments to regional

The AAMC proposes the creation and testing of a concept called the Healthcare Innovation Zone (HIZ). The HIZ is an integrated delivery network encompassing the full spectrum of comprehensive and community care, organized around a centralized system that includes an academic medical center (AMC). Our goal is to build upon the accountable care organization (ACO) and medical home concepts developed by others (for example, MedPAC and Brookings), and then test it using our member institutions and their partners, with the ultimate goal of enhancing clinical practice to improve the health of our nation.

We urge the House to include language that would provide planning grants to academic medical systems that would like to pursue development of HIZs. We have draft language that we would be happy to share and discuss with Staff.

For the purposes of this pilot, we believe that the Stark and other laws that may prevent the adoption of an ACO, should be waived for the duration of the pilot.

The AAMC applauds the effort to allow PGP demonstration participants to transition into the ACO pilot.

### **Section 1302. Medical Home Pilot Program**

As stated, the Pilot is split into two qualifying models, “independent patient-centered medical homes” and “community-based medical homes.” Each model has a separate definition for “qualified beneficiary” different payment allocation models and duration of pilots. A consistent approach and definition for the medical home pilot would be advantageous for interested, eligible participants.

*(c)(1)(E) Implementation: “The pilot program under this subsection shall begin no later than 6 months after the date of the enactment of this section.”*

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We would like clarification on whether the independent patient-centered medical home model pilot will be based on the model designed for the TRHCA Medicare Medical Home Demonstration project. If CMS needs to set up a new or modified model, then the six-month timeframe would be particularly onerous for the Secretary and providers interested in participating.

### **Section 1303. Rate increases for Selected Primary Care Services**

The AAMC supports the 5 percent bonus primary care, provided this bonus is NOT budget neutral.

The definition for professionals eligible for the 5% bonus should be expanded to include the Principal Care Physicians (as defined in the sec 1302, the patient-centered medical home). As noted in the sec 1302, principal care physicians often assume the management and care of patients with chronic conditions and serve the primary care functions for this patient population.

### **Subtitle D—Physician Payments Sunshine Provision**

The AAMC has strongly supported increased transparency in industry funding and recommends that, on page 572, under (f)(8)(A)(iv) after “Research funding or grant” **add “to an institution with an individual investigator indentified.”** We believe this will further clarify that the research grants are being made to the institutions and are not income to the individual investigator who is identified as the PI on the grant.

We also note **the House draft does not include provisions to pre-empt state laws, and would recommend that the provisions under (d)(3) in S. 301 be included in the House bill.**

### **Comparative Effectiveness Research**

The AAMC thanks the Chairmen for their strong commitment to and support for the Comparative Effectiveness Research. **We are pleased that the draft includes provisions to authorize a Center of Comparative Effectiveness Research** at AHRQ overseen by an authoritative and independent Comparative Effectiveness Research Commission. We look forward to working with the Committee as the legislation moves forward. The draft bill has only been reviewed by AAMC staff, who make the following observations.

### **Section 1401. COMPARATIVE EFFECTIVENESS RESEARCH**

With regard to the creation of Section 1181, the establishment of a Center for Comparative Research, the AAMC believes the work of the Commission and of the Clinical Perspective Advisory Panels it establishes would be enhanced by formal efforts to support patient and consumer representatives. We suggest that the Commission be charged to provide support and resources to help patient and consumer representatives on the Commission (and on any advisory panels appointed by the Commission) to effectively participate in technical discussions regarding the complex and highly consequential research topics engaged by the Commission and Center.

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The description of the Clinical Perspective Advisory Panels (Paragraph (H)) would be enhanced by clarifying that when the relevant clinical perspective advisory panel for each research priority consults with patients it does so with those who are representative of the types of patients and concerns that real world patients confront when making decisions with clinicians at the point of care.

The AAMC strongly supports developing and using CER through means that are synergistic with continued discovery of clinical innovations through biomedical science. In this exciting era of burgeoning discoveries in the health sciences (such as genomic medicine) it is essential to advancing the health of the public that we continue to promote a robust culture of discovery spanning all the health care sciences, including biomedical, translational, comparative effectiveness, and health services. Accordingly the Commission should be charged with reporting by 2011 to Congress and the HHS Secretary on regulatory and legislative changes needed to efficiently support through health insurance the clinical costs of research on promising innovations through coverage with evidence development, procedure and device registries, and other forms of conditional coverage to encourage clinical research on the comparative effectiveness of promising innovations.

With regard to **Section 9511** (HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND), the AAMC believes there is a large societal need for more comparative effectiveness research that greatly exceeds the \$ 110 Million to be available in year 2112 and the \$375 Million per year provided through the CERTF following 2013. **We recommend that the funds for 2012 be increased to \$150 M.** We further recommend that the cap on Medicare contributions after 2012 be lifted, and that following 2015 the Secretary have the authority to adjust the fair share per capita amount be adjusted to yield \$600M by to the CERTF per annum( adjusted by the annual increase in the medical care component of the CPI) .

### **Hospital Payment Policy**

Overall teaching hospital payments will be affected by proposed policies and we share the concerns of the American Hospital Association and others in the hospital community with provisions intended to:

- Permanently reduce the annual market basket update for inpatient, outpatient and post-acute care services to account for "productivity gains;"
- Pay hospitals Medicare payment rates for individuals enrolled in a new public health insurance plan (as part of a national health insurance exchange) for the first two years, after which the Secretary would set payment rates;
- Implement an aggressive readmissions policy that would limit payment to hospitals

We have therefore limited our comments to those areas of unique concern to teaching hospitals but are happy to discuss any of the broader hospital payment policies outlined in the discussion draft.

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**Section 1151: Reducing Potentially Preventable Hospital Readmissions**

The AAMC is supportive of efforts to reduce unnecessary readmissions and improve the quality of care a patient receives. However, we have a number of concerns with this proposal as it is currently written and several suggestions as to how this provision could be improved.

**At the outset, we support defining the base operating DRG payment to exclude IME, DSH, outlier and low volume payments.** We also appreciate the bill recognizes that safety net hospitals may have higher readmission rates due to patient noncompliance and other factors and provides additional assistance to these hospitals. However, we also believe that the bill should explicitly direct the Secretary to include socio-economic status factors in the methodology used to determine a hospital's "expected readmissions."

We believe that the following patients should be excluded from any type of readmission policy: Medicare/Medicaid dual eligible patients, and patients who are eligible for Medicare due to a disability or end-stage renal disease. We also believe that for the conditions chosen, the methodology should exclude patients who have a secondary diagnosis related to psychoses and substance abuse.

The readmission payment policy should focus on those readmissions that are both unplanned and related to the initial admission. Moreover, we also believe that any payment reductions should be applied only to cases associated with the selected readmission DRG category. Targeting the reductions to specific condition areas provides greater incentive to make improvements compared to an across-the-board reduction.

**We strongly believe that a 7 or 14 day time period is more appropriate than 30 days for a readmission policy,** as the longer the time period, the greater the potential for factors beyond a hospital's control affect the potential for readmissions. We also believe that if new readmission measures are to be developed, at a minimum they must be NQF endorsed in order to be included in a readmission policy.

**Division C: Public Health and Workforce Development**

The AAMC thanks Energy and Commerce Committee Chair Waxman, Subcommittee Chair Pallone, and members of the House Energy and Commerce Committee for their longstanding commitment to and support for the health professions training programs authorized under Title VII of the Public Health Service Act. We are pleased that the discussion draft includes provisions to reauthorize the Title VII programs and look forward to working with Congress as the legislation moves forward. The draft bill only has been reviewed by AAMC staff, who make the following observations.

**Sec. 2002: Public Health Investment Fund**

This section establishes a "Public Health Investment Fund," from which House and Senate appropriators may "increase funding, over the fiscal year 2008 level" for designated programs (including the Community Health Center program, the National Health Service Corps, and the Title VII health professions training programs, among others). The bill deposits into the fund

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\$4.7 billion for FY 2010, \$5.6 billion for FY 2011; \$6.9 billion for FY 2012; \$7.7 billion in FY 2013; and, \$8.8 billion in FY 2014.

- This section appears to establish a mandatory funding stream that supplements the regular appropriations process for select programs under the Public Health Service Act (the following comments are based on this interpretation of the language). The AAMC appreciates the bill's attempt to stabilize funding for health workforce programs by ensuring the availability of additional funds, particularly since drastic funding cuts have hampered the programs' ability to achieve their full potential. However, the bill strikes the existing funding authorizations for the National Health Service Corps and the designated Title VII programs. In addition to the Fund, the AAMC urges the committees to retain the existing funding authorizations for the programs to allow funding through the regular appropriations process.
- Additionally, what is intended by the bill's provision directing appropriators "to increase funding, over the fiscal year 2008 level" for the designated programs? Is the intent to ensure that the designated programs receive at minimum the same funding levels as FY 2008?

## **TITLE II: WORKFORCE**

### ***Subtitle A – Primary Care Workforce***

#### **Sec. 2201: National Health Service Corps**

This section authorizes the NHSC to accept less than full-time clinical practice to fulfill the NHSC service requirement. Sec. 2201 directs the Secretary to adjust NHSC program benefits for part-time service by increasing the length of service or decreasing the NHSC award in such cases. The bill also increases the maximum loan repayment annual award from \$35,000 to \$50,000 in FY 2011 and allows the Secretary to increase this amount in future years to account for inflation.

- The AAMC supports allowing part-time service to qualify towards the NHSC service requirement. This will allow the NHSC to recognize and respond to physician lifestyle and career concerns, including the large number of physicians over age 55 who are considering alternatives to retiring; maternity and paternity periods as well as child care; research opportunities; and career development following service in the NHSC.
- The cost of medical education can be daunting for prospective students and future physicians. Medical students and residents are concerned about managing their substantial debt burden. This can play a factor in career decisions and drive physicians away from primary care specialties. The NHSC scholarship and loan repayment programs provide important relief and help ensure access to health professions education for students from all backgrounds. In 2008, the median medical education debt reached \$150,000. The proposed \$50,000 maximum annual award limit will allow many young

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physicians to repay their student loans within 3 years, increasing interest the NHSC and exposing more physicians to primary care careers in underserved areas.

### **Sec. 2202: Authorization of Appropriations**

This section increases via the Public Health Investment Fund (Sec. 2002) the authorization for the NHSC to \$300 million through FY 2014 for NHSC Recruitment appropriations and \$75 million through FY 2014 for NHSC Field appropriations. The NHSC Recruitment appropriations funds NHSC Scholarship and Loan Repayment Program awards, whereas the NHSC Field appropriations recruitment and retention administrative activities.

- The AAMC supports efforts to increase the size of the NHSC, but cautions that a static authorization will not allow for future program growth. In addition to the authorization in Sec. 2202, the AAMC encourages the committees to retain the existing NHSC funding authorization through the regular appropriations process. Steady and sustained increases in the NHSC will improve access to health care for the growing numbers of underserved Americans, provide incentives for practitioners to enter primary care, reduce the financial burden that cost of health professions education places on new practitioners, and help ensure access to health professions education for students from all backgrounds.

## **Chapter 2 – Promotion of Primary Care and Dentistry**

### **Sec. 2212: Primary Care Student Loan Funds**

This section updates the HRSA Title VII student loan programs, including the Primary Care Loan. Specifically, the bill creates a new formula that adjusts the loan interest rates based on the Department of Education Stafford loan interest rate; aligns the service requirement with comparable Department of Education loan forgiveness programs; establishes a more reasonable default rate that will not deter potential applicants from entering primary care; and provides for a review of the HRSA student loan guidelines.

- The AAMC strongly supports these revisions to help ensure access to health professions education for students from all backgrounds.
- In FYs 2005 and 2006, Congress rescinded a total of \$47.5 million from the Title VII and VIII health professions programs, the majority coming from the Primary Care Loan program. The AAMC also opposes these rescissions. Rescinding funds not only neglects financially disadvantaged and minority students, but also threatens the stability of our nation's health care infrastructure. No federal funds are required to maintain these programs. They receive no annual appropriation, thereby posing no burden on taxpayers. They are funded with the interest from student/graduate repayment, creating a self-sustaining revolving fund designed by Congress to address shortages in the health professions workforce. To help prevent future rescissions, the AAMC supports language in Sec. 421 of the Senate's draft "Affordable Health Choices Act" as follows: "SENSE OF CONGRESS. – It is the sense of Congress that funds repaid under the loan program

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under this section should not be transferred to the Treasury of the United States or otherwise used for any other purpose other than to carry out this section.”

**Sec. 2213: Training in Family Medicine, General Internal Medicine, General Pediatrics, Geriatrics, and Physician Assistantship**

This section amends the Title VII primary care medicine programs to include geriatric medicine among primary care specialties eligible for grant funding and to allow grantees to use funds to train physicians teaching in community-based settings. The bill requires the Secretary to make grants for academic administrative units (“shall” instead of the current “may”) and strikes the current priority for academic administrative unit (AAU) applicants that propose collaborative projects between departments of primary care. The bill also elevates to funding preferences two current funding priorities (a record of training providers that enter and remain in primary care and a record of training individuals from “underrepresented minority groups” or disadvantaged backgrounds), and elevates to a funding preference a current “special consideration” on teaching programs targeting vulnerable populations (including older adults). Additionally, the bill allows the Secretary to require collaboration and consultation with “pertinent workforce programs” at HHS and the Departments of Labor and Education; to “adequately support” existing programs to address new departmental initiatives; and to consider capabilities of existing programs before creating new, parallel programs.

- The AAMC Title VII Reauthorization Committee recommended restructuring the primary care programs to preferentially award grants to applicants that enter into a formal relationship and submit a joint application with a Federally Qualified Health Center, FQHC Look-Alike, Area Health Education Center, clinic located in a HPSA or MUA, or a clinical practice setting in which at least 40 percent of patients are either uninsured or supported by Medicaid. The AAMC encourages inclusion of this provision to help better align grant funding with training opportunities in underserved settings.
- The AAMC Title VII Reauthorization Committee also recommended creating a new program supporting demonstration programs to promote new competencies in selected emphasis areas identified by the HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry. The AAMC urges inclusion of this provision to support curricular innovations in primary care.
- With the inclusion of geriatric medicine as an eligible specialty for grant funding, the bill establishes an automatic preference for such applicants, given the proposed preference for training programs targeting older adults (among other vulnerable populations). Is this the committee’s intent?

**Sec. 2215: Authorization of Appropriations**

The bill authorizes \$200 million for FYs 2010-2014 from the Public Health Investment Fund (Sec. 2002) for the Frontline Health Providers program (Sec. 2211), Title VII Primary Care Loan Program, the Title VII Primary Care Medicine programs, and the Title VII Primary Care Dentistry programs.

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- It is unclear why the funding authorization for the proposed “Frontline Health Providers” program is included with the authorization for the Title VII primary care programs. Given that the proposed new program is authorized under Title III of the PHSA, has an apparent focus outside of primary care, and is structured as a service-obligated placement program, we suggest that funding for the Frontline Health Providers program be authorized distinctly from the Title VII programs.
- In addition to funding provided through the Public Health Investment Fund, the AAMC urges the committees to retain the existing funding authorizations for the programs to allow funding through the regular appropriations process. The AAMC’s Title VII Reauthorization Committee recommended \$198 million for the Title VII primary care programs, and, more recently, HRSA’s Advisory Committee on Training in Primary Care Medicine and Dentistry recommended \$215 million for the programs. With the addition of geriatrics to the primary care medicine programs, as well as the inclusion (as drafted) of the proposed scholarship and loan repayment program for “Frontline Health Providers,” we note that the bill’s recommended funding level is insufficient if it will not be supplemented by funding through the regular appropriations process.

#### *Subtitle D – Adapting Workforce to Evolving Health System Needs*

#### **Chapter 1 – Health Professions Training for Diversity**

#### **Sec. 2241: Centers of Excellence and Sec. 2242: Scholarships for Disadvantaged Students, Loan Repayments and Fellowships Regarding Faculty Positions, and Education Assistance in the Health Professions Regarding Individuals from Disadvantaged Backgrounds**

Sec. 2241 amends the Title VII Centers of Excellence program to specify a focus on underrepresented minority individuals enrolled “in health professions programs.” The bill updates the formula for funding allocations and adds to the requirements that grantees use funding to conduct accountability and other reporting activities as required by the Secretary. Sec. 2242 increases the maximum award for Title VII faculty loan repayment to \$30,000, and after FY 2011, directs the Secretary to adjust the maximum award on an annual basis to reflect inflation.

- The AAMC strongly supports the reauthorization of the Title VII Minority and Disadvantaged Health Professions Programs (PHSA Sections 736-739). The AAMC is deeply committed to increasing diversity in the health professions and eliminating health disparities relative to race and ethnicity, and these programs are key components in pursuing these goals.
- In addition to support for these existing programs, the AAMC Title VII Reauthorization Committee also noted the need for increased emphasis on the development of underrepresented minority faculty, as these mentors create an environment that allows minority health professions students to succeed and graduate to provide care in their communities. Considering the shortage of minority faculty in health professions schools,

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the AAMC Committee also recommended expansion of minority faculty development through a new program designed to increase the number of underrepresented minority faculty. The AAMC Committee recommended \$5 million for the new program.

## **Chapter 2 – Interdisciplinary Training Programs**

### **Sec. 2251: Cultural and Linguistic Competence Training for Health Care Professionals**

This section amends an existing program under Title VII (Sec. 741) to require (instead of allow) the Secretary to make grants to accredited health professions schools, academic health centers, and State and local governments to address health disparities (as defined under PHSA Sec. 3171, as added by the bill's Sec. 2301) by promoting cultural and linguistic competency. Grants should be used to test, develop, implement and evaluate training models on cultural and linguistic competence and to facilitate faculty and student research on such health care. The bill establishes funding preferences for applicants that address more than one health profession discipline and those that partner with institutions serving the relevant population.

- We suggest striking the word “test” in (b)(1).
- Please see comments on definition of “health disparities” under Sec. 2301.

### **Sec. 2252: Innovations in Interdisciplinary Care Training**

This section adds a new program to Title VII to award grants promoting training in interdisciplinary and team-based care and coordination within academic health centers. Eligible entities include: accredited health professions schools, public and non-profit hospitals, or public or private non-profit entities. Applicants must assess barriers to health care and specify a plan to establish a formal relationship with community-based partners. Grantees must plan and implement interdisciplinary training curricula; conduct interdisciplinary research addressing barriers; and create new models of teaching and evaluating patient care. The bill establishes preferences for applicants that have a record of interdisciplinary collaborations; that have a high rate of placing graduates in underserved or rural areas; and, that have a high rate of training professionals in primary care or other “high priority” specialties.

- The bill does not address the Title VII Area Health Education Centers (AHEC) program (PHSA Sec. 751, 42 USC 294a), but many of the objectives of the proposed new program seem similar. Is the proposed new program intended to replace the AHEC program?

## **Chapter 3 – Advisory Committee on Health Workforce Evaluation and Assessment**

### **Sec. 2261: Health Workforce Evaluation and Assessment**

This section directs the Secretary to establish under Title VII a new Advisory Committee on Health Workforce Evaluation and Assessment, comprised of 15 individuals representing a broad range of stakeholders. Committee members are appointed by the Secretary in consultation with the Comptroller General for staggered three year terms. Committee members must “adequately

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represent” urban, rural, and non-metropolitan areas, as well as populations underrepresented in the health professions. The majority of members should be individuals that are not directly involved in health professions education and practice. The committee is directed to: make recommendations in consultation with the Department of Labor on classifications of the health care workforce; make recommendations on standardized methodology and procedures to enumerate the health care workforce; review health care workforce supply and demand; make recommendations on workforce priorities, goals, and policies (including outcomes measures for “Federal workforce programs”); and submit to the Secretary and to Congress an annual report on these issues. Additionally, the committee is required to collaborate with existing advisory bodies at HRSA, and cannot be terminated within 5 years of enactment.

- The success of the advisory committee depends in part on the availability of funding for the National Center for Health Workforce Analysis and other data programs. The existing workforce information and analysis component of Title VII has received no funding since FY 2005. Given this trend, we are concerned that the commission may be forced to produce reports without comprehensive, current data to inform its recommendations. As such, we suggest that the commission should not form until there is sufficient data available.
- What is the purpose for limiting participation of health professionals on the advisory committee? The bill requires participation of only one health professional. We are concerned that the majority of the committee could be comprised of members that have no expertise on health professions education and practice. Given the functions and charge of the proposed committee – and the breadth of the health professions workforce – if a committee is to form, we suggest that it also require participation of at least one physician and at least one representative of the academic medical community. A diversity of stakeholders should not come at the expense of expertise in the field.
- As drafted, the scope of the Advisory Committee is very broad; is it intended for the committee to make recommendations for workforce performance measures outside of the health care workforce? To focus the committee’s charge, we suggest adding “under this title” after “programs” in 2261(c)(4).

## **Chapter 4 – National Center for Health Workforce Analysis**

### **Sec. 2271: Health Care Workforce Program Assessment**

This section establishes at HRSA a National Center for Health Workforce Analysis to collect, analyze, and report data on the health care workforce and related federal programs; develop and publish benchmarks for performance for Federal workforce programs (including tracking health workforce needs over time); establish a national workforce database on the Internet “which collects data from internal and external data sources”; establish a registry of Title VII grants; and compile and disseminate workforce information through reports. The center may award contracts to eligible entities to fulfill its duties.

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- The new National Center for Health Workforce Analysis appears to replace the existing regional centers for health information workforce and analysis under Title VII. The AAMC supports the continuation and expansion of the existing regional centers in addition to the National Center.
- The AAMC's Title VII Reauthorization Committee recommended the establishment of a national workforce database to track the location of health professionals educated and trained in programs receiving Title VII support; and the development of outcomes measures and reliable benchmarks to evaluate the success of the Title VII programs. The AAMC supports the provisions outlined in Sec. 2271 that help accomplish these goals. However, to strengthen the proposed new center's ability to achieve these goals, we suggest adding the phrase "under this title" after "programs" in (a)(2)(B).

### **Sec. 2281: Authorization of Appropriations**

(a) This subsection authorizes \$90 million from the Public Health Investment Fund (Sec. 2002) for FYs 2010-2014, for the Title VII diversity programs, including the Centers of Excellence, Scholarships for Disadvantaged Students, Faculty Loan Repayment Program, and Health Careers Opportunity Program.

- In addition funding provided through the Public Health Investment Fund, the AAMC urges the committees to retain funding authorizations through the regular appropriations process. The AAMC's Title VII Reauthorization Committee recommended \$155 million for PHSA sections 736-739. The programs received \$117 million in FY 2005 and the President's FY 2010 Budget Request recommends \$100.8 million for the programs. We note that the bill's proposed authorization level is insufficient without authorizing funding through the regular appropriations process.

(b) This subsection authorizes \$70 million from the Public Health Investment Fund (Sec. 2002) for FYs 2010-2014, for the Title VII Cultural and Linguistic Competence Training program, the proposed new Innovations in Interdisciplinary Care Training program, the National Center for Health Workforce Analysis, the Advisory Committee on Health Workforce Evaluation and Assessment, and the Title VIII Cultural Linguistic Competence Training for Nurses program.

- It is unclear why the bill couples the funding authorization for the workforce analysis program and the proposed new advisory committee with authorization for the proposed interdisciplinary training programs. The existing Title VII program for workforce information and analysis has not received an appropriation since FY 2005. Given this pattern and the importance of data collection and analysis, we recommend ensuring a dedicated funding stream through the Public Health Investment Fund specifically for the workforce analysis programs. Further, in addition to funding provided through the Fund, the AAMC urges the committees to authorize funding for the programs through the regular appropriations process.
- It also is unclear why funding for the proposed Title VIII Cultural Linguistic Competence Training for Nurses program is authorized with funding for the Title VII programs. We suggest that funding for this program is more appropriately authorized with other Title VIII programs under the bill's Sec. 2221 (and PHSA Sec. 871).

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- The bill does not address authorization for existing Title VII interdisciplinary training programs, such as the Title VII geriatric training programs – including the geriatric education centers and geriatric academic career awards (PHSA Sec. 753) – and the Title VII AHEC program (PHSA Sec. 751). The AAMC supports reauthorization of these critical programs.

### **TITLE III: PREVENTION AND WELLNESS**

#### **Sec. 2301: Prevention and Wellness**

This section adds a new title to the PHSA addressing prevention and wellness activities. Under the new title, proposed new PHSA Section 3171 defines several terms, including “health disparities.”

- We suggest that the definition be amended to clarify that the “differences” that indicate the presence of disparities are adverse and originate in social, economic, and racial inequities.
- Additionally, we recommend adding socioeconomic status, disability, and sexual orientation to the definition by modifying it to read: “... a population may be delineated by race, ethnicity, geographic setting, socioeconomic status, disability, sexual orientation, or other category determined appropriate by the Secretary.”

Again, we wish to thank the Chairmen for the opportunity to comment on this draft and we are happy to discuss any and all topics with you or your staff.

A handwritten signature in black ink, appearing to read 'Atul Grover', with a stylized flourish at the end.

Atul Grover, MD, PhD, FACP, FCCP  
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