Dear Chairman Sanders, Ranking Member Burr, and Members of the Subcommittee:

On behalf of the Association of American Medical Colleges (AAMC), I write to thank you for convening today’s hearing, “Addressing Primary Care Access and Workforce Challenges: Voices from the Field.” The AAMC is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

As the subcommittee considers the testimony from the hearing, the AAMC is pleased to provide the following information regarding physician workforce projections, medical education, and the irreplaceable role teaching hospitals play in training the next generation of health professionals and ensuring access to critical health care services.

**Physician Shortages in Both Primary and Specialty Care Will Affect Seniors**

The AAMC applauds Subcommittee Chair Bernie Sanders and Ranking Member Richard Burr for their continued commitment to averting emerging gaps in access as the demand for health care services increasingly exceeds the supply of physicians and other health professionals. As has been widely reported, the nation faces a shortage of 91,500 physicians in the next decade, largely due to our aging patient population battling multiple chronic conditions; an influx of up to 32 million newly insured individuals entering the health care system with previously untreated conditions; and the looming retirement of current practitioners.

The deficit of physicians spans evenly across both primary and specialty care, with estimated shortages of over 45,000 primary care physicians and 46,000 specialists expected by 2020. The shortfall in the number of primary care physicians will impede access to preventive care for millions, resulting in missed opportunities in some cases to prevent the progression of various health conditions or to manage chronic conditions.

At the same time, the growing shortage of specialists increasingly will limit health care access for patients with cancer, Alzheimer’s disease and dementia, hip fractures, and other ailments.
These trends are of particular concern as more and more Baby Boomers require long-term specialty care for age-related illnesses and disabilities. Consider, for example, the leading causes of death for seniors. According to the Centers for Disease Control and Prevention (CDC)’s most recent National Vital Statistics Reports, in 2010, heart disease accounted for 26.5 percent of deaths for individuals over the age of 65, and 30.8 percent of deaths over the age of 85. Cancer caused 22.1 percent of deaths for individuals over 65 and 12.4 percent of deaths for individuals over 85. While a lifetime of reliable access to primary care may help catch or manage a fraction of these diagnoses in their early stages, for adults whose conditions continue to progress over time – and for those whose conditions have been treated or who face a high risk of recurrence – access to cardiologists, cardiothoracic surgeons, oncologists, and other specialists also will be essential.

Similarly, the CDC reports that unintentional falls afflict over 2.4 million seniors over age 65 each year, accounting for 62.2 percent of all non-fatal injuries for adults over age 65 and 80.2 percent of injuries among adults over age 85. According to the American College of Surgeons National Trauma Data Bank 2013 Annual Report, falls accounted for over 40 percent of trauma cases, and a substantial number of these patients are over age 65.

These examples represent the types of health care services that cannot be fully avoided even with the best, most comprehensive primary care services. Accordingly, patients of all ages will be best served with reliable access to sufficient numbers of both primary and specialty care physicians. As thousands of Americans celebrate their 65th birthday each day for the next decade, and as more seniors live longer lives, these health care needs only will continue to grow.

**Expanding the Physician Workforce Relies on Congress Lifting the Cap on GME Support**

As the demand for physician services continues to grow, the supply of physicians has not been growing at the same pace. Medical schools already have taken the first critical step to address this increased demand, expected by 2018-19 to enroll 30 percent more students compared to 2002. Before medical graduates can practice independently, they must complete advanced supervised training in the form of a residency at a teaching hospital. However, Congress has limited the availability of training positions by effectively freezing Medicare support for graduate medical education (GME) at 1996 levels.

Based on the AAMC’s preliminary analysis of data from the recent 2014 Main Residency Match, it appears that once again several hundred U.S. medical students did not match to a first-year residency training program. At a time when the nation faces a looming and serious physician shortage, we remain extremely concerned that the 17-year cap on federal support for physician training will impede the necessary growth in residency positions that must occur to ensure that our growing and aging population will receive the care it needs.

To meet the country’s workforce needs, the AAMC supports bipartisan legislation introduced in the House (H.R. 1180 and H.R. 1201), as well as legislation introduced in the Senate (S. 577), that would increase the number of Medicare-supported residency slots by 15,000 over five years, with specified priorities for distributing the new slots. For example, priority would be given to states with new medical schools and hospitals affiliated with medical schools that have sent 40 percent of their graduates to primary care residency programs, and hospitals that emphasize
training in community health centers, community-based settings, or hospital outpatient departments.

These bills would direct half of the newly available positions to training in shortage specialties as identified and verified by federal entities. Given the dynamic nature of communities’ health care workforce needs, it is imperative to target increases in federally funded residency positions as these bills do: through ongoing analysis of health care utilization and demand. Prescribing a static specialty composition or targeting increases to any singular discipline in legislation will preclude physician training efforts from adapting to varying and evolving local workforce needs.

Like our member medical schools, the nation’s teaching hospitals too have stepped up to address expected shortages by voluntarily supporting (with no Medicare GME support) new residency training positions, at a cost of $1 billion per year. However, ongoing Medicare and Medicaid cuts to hospitals (including teaching hospitals) make significant further expansion of residency training programs highly unlikely. For some programs, the declining clinical revenue may force reductions or closures.

Likewise, given the continued increase in demand for physician services, any proposals to undermine GME support to teaching hospitals threaten to weaken the nation’s physician training capacity at a most inopportune moment. According to the recently published results of an August 2013 survey conducted by the Accreditation Council for Graduate Medical Education (ACGME), 83 percent of respondents (from both teaching hospitals and medical schools) are already engaged in leadership-level discussions about how they would reduce residency positions if Medicare GME support were reduced.

The survey posed three scenarios under which Medicare funding for GME could be reduced, and respondents reported that additional financial pressures would trigger program reductions/eliminations across training programs in both primary and specialty care. The results indicate that:

- If Medicare reduced GME support by 10 percent, as proposed in President Obama’s FY 2015 budget request, close to one-third of respondents (30 percent) reported that they would cut or close their current number of residency positions.
- If Medicare reduced GME support by 33 percent, 60 percent of respondents reported that they would cut or close their current number of residency positions.
- If Medicare reduced GME support by 50 percent, three-quarters of respondents (75 percent) reported that they would cut or close their current number of residency positions.

These sobering forecasts underscore the critical importance of preserving and augmenting the federal GME investment and enabling teaching hospitals to continue preparing the next generation of physicians to meet the country’s growing health care needs.

Moreover, proposals to redirect Medicare GME support to entities that do not serve substantial numbers of Medicare beneficiaries are similarly problematic and concerning for seniors and the country’s population as a whole. Currently, Medicare reimburses teaching hospitals for only a portion of the physician training costs they incur, based on the volume of Medicare patients at each institution (the “Medicare share”). Payments for Direct Graduate Medical Education (DGME) expenses – such as resident stipends and benefits, faculty salaries and benefits, and
allocated institutional overhead costs – cover less than one quarter of the total direct expenses that teaching hospitals incur.

Most teaching settings can receive Medicare DGME payments. Many community health centers and similar training venues are currently eligible for DGME payments. Like teaching hospitals, those payments would be calculated based on the facility’s Medicare share. Congress repeatedly has clarified that Medicare GME support should remain tied to the level of Medicare services provided, rather than diverting limited Medicare funds to providers that do not treat a substantial number of Medicare beneficiaries.

Teaching hospitals also receive Medicare Indirect Medical Education (IME) payments, but these are patient care payments that recognize the additional costs incurred by teaching hospitals because they maintain specialized services and treat the most complex, acutely ill patients. For example, AAMC member teaching hospitals operate 80 percent of Level 1 Trauma centers, 79 percent of all burn care units, 40 percent of neonatal- and 61 percent of pediatric ICUs, nearly half of surgical transplant services, and provide a range of other highly sophisticated services not offered elsewhere in communities. Compared with physician offices and non-teaching hospitals, teaching hospitals often care for patients that are sicker, poorer, and more likely to be disabled or non-white. IME payments are meant to partially offset these costs. Providers that do not incur the unique patient care costs associated with caring for highly complex, severely ill inpatients (i.e., ambulatory sites that largely provide primary, non-acute care) do not qualify for these payments.

**Affecting Practice Choices of Medical Graduates**

Notwithstanding recent upticks in the number of medical graduates opting to pursue primary care, some have expressed concern about the level of interest in primary care careers (even among pre-medical students) and its implications, given projected shortages. As described in the AAMC’s April 2013 statement to the subcommittee, both new and existing medical schools have invested in a variety of initiatives to address these concerns, such as expanding primary care faculty and resources, expanding or modifying clinical rotations, and creating new or expanded extracurricular opportunities. Similarly, a number of institutions support initiatives designed to prepare learners to serve in rural and/or urban underserved communities.

While all medical schools are committed to producing primary care physicians in accord with the nation’s needs, it is also important to note that each medical education program is responsible for establishing a curriculum aligned with its own institutional missions and educational objectives within the framework of general competencies required for accreditation by the Liaison Committee on Medical Education (LCME). Medical schools serve society in many ways – they conduct groundbreaking medical research that helps address the health needs of all patients; they provide vital community services such as geriatric care, nutrition counseling, health clinics, and free screenings for the uninsured and underinsured; and they work to improve medical care not only for Americans, but also for disadvantaged populations globally. Measuring their contributions to society solely through their efforts to cultivate interest in primary care overlooks the vital role that many of these institutions play in advancing other essential components of quality health care.

Moreover, the AAMC strongly supports the ability of individual medical students and physicians to determine for themselves which area of medicine they wish to pursue. While medical schools
actively carry out their responsibility to present an array of rich educational experiences across disciplines of medicine, ultimately, each individual student must determine the specialty that best suits his or her personal and career goals. Education and training cannot overcome the intense market incentives that influence physician choices.

Health needs and demands vary at the local level, and also over time. Some training programs produce physicians who ultimately practice in other regions of the country with health needs that differ significantly from the region in which they trained. Additionally, and perhaps most importantly, personal decisions (e.g., family demands, the careers of spouses, personal lifestyle choices) are major factors in determining where a physician will practice, as well as in which specialty he or she might practice. These factors are an important component of thoughtful workforce analyses that have little relationship to educational programs themselves. Gauging the “success” of a medical school or a residency program on the basis of outcomes that are largely the result of these personal choices is both unreasonable and likely to be ineffective.

Many claim prohibitive debt levels lead medical students to choose careers other than primary care, but surprisingly little evidence supports this assertion. In fact, a thorough review of the academic literature shows little to no connection between debt and specialty choice. Rather, studies affirm specialty choice is a complex and personal decision involving many factors. According to AAMC’s annual survey of graduating medical students, the most important factors are a student’s personal interest in a specialty’s content and/or level of patient care; desire for the “controllable lifestyle” offered by some specialties; and the influence of a role model in a specialty. Student debt consistently ranks toward the bottom of the list for this question every year.

Further, federal programs, such as the National Health Service Corps (NHSC), offer incentives to help physicians manage their debt. A January 2013 study in Academic Medicine found that “physicians in all specialties, including primary care, can repay the current median level of education debt. At the most extreme borrowing levels … options exist to mitigate the economic impact of education debt repayment. These options include an extended repayment term or federal loan forgiveness/repayment program, such as IBR, PSLF, and the NHSC.”

With the Affordable Care Act’s mandatory funding for NHSC set to expire at the end of FY 2015, the program is in jeopardy. The AAMC, as a member of the NHSC Stakeholders, supports further expanding the NHSC to supplement existing health professions training investments. A funding approach that includes both mandatory and discretionary funding ensures annual flexibility with out-year stability. As such, we encourage congressional authorizers and appropriators to work together before current funding runs out.

In addition to the NHSC, other programs at the Health Resources and Services Administration (HRSA) have proven successful in guiding students toward a career in primary care and underserved communities. The Title VII health professions programs offer support for educational opportunities in these settings. The programs serve as a catalyst for innovations in education and training, helping the workforce over the years adapt to the nation’s changing workforce needs. Similarly, the Children’s Hospitals Graduate Medical Education program provides critical support to strengthen the future primary and specialty care workforce for the nation’s children, and we thank Committee members for their leadership in advancing the recent reauthorization of the program.
The Teaching Health Center (THC) program is a more recent HRSA initiative, established in the Affordable Care Act and funded with a mandatory appropriation. The THC program provides payments of $150,000 per resident, per year, to community-based, ambulatory patient care centers that operate primary care residency programs. These payments are nearly double the $80,000 payments provided to participants of the recent Primary Care Residency Expansion program, and similarly, at a far higher level than Medicare supports teaching hospitals. AAMC continues to support HRSA funding for this new program, given that the agency oversees the federal health center program, health professions workforce development programs, and other community-based entities. We look forward to studying the outcomes of the initial cohort of THCs, and how continued HRSA funding can sustain the higher payments made to these facilities.

Again, the AAMC commends the Subcommittee for continuing this important conversation. Medical schools and teaching hospitals make unparalleled contributions to improving medical care in the U.S. and around the globe through their integrated missions of education, research, and patient care. As the nation faces an unprecedented demand for health care services, continued support for these institutions will be essential. As you move forward, we welcome the opportunity to work with you and your staff toward our mutual goal of strengthening access to health care for patients across the country.

Sincerely,

Atul Grover, M.D., Ph.D.
Chief Public Policy Officer