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# POLICY PRIORITIES TO IMPROVE THE NATION'S HEALTH

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**Association of  
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**November 2016**

**Darrell G. Kirch, M.D.**

President and Chief Executive Officer

Dear President-Elect Trump:

The enclosed briefing book represents the commitment of the Association of American Medical Colleges (AAMC), a not-for-profit 501(c)(3) entity, to assist your administration in drawing on the experience of our 147 U.S. medical schools, nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers, and more than 80 academic societies in addressing the nation's health policy challenges and opportunities. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

Academic medicine is the combination of medical schools, teaching hospitals, and their faculty members, staff, students, and resident physicians. Medical schools and teaching hospitals sustain an environment where basic, clinical, and health services research can flourish alongside clinical care and training. These organizations and individuals share a commitment to providing education and graduate training to future physicians, biomedical scientists, and other health care professionals; conducting biomedical and clinical research; and advancing medical knowledge, therapies, and technologies to prevent disease, alleviate suffering, and improve quality of life.

**Academic Medicine Plays a Pivotal Role in U.S. Health Care**

In settings of constant inquiry, medical schools and teaching hospitals integrate the full spectrum of clinical care, training, and research to provide cutting edge health care:

- *Medical Educators*: Through continual renewal and innovation at both the national level and at individual institutions, America's system of medical education prepares physicians and scientists to meet the nation's evolving health needs.
- *Medical Science Centers*: Our medical schools, teaching hospitals, and faculty pioneer cures and bring them to patients. Over 50 percent of all external research funded by the National Institutes of Health (NIH) is performed by scientists at medical schools and teaching hospitals.
- *Medical Safety Net*: Major teaching hospitals make up only 5 percent of all hospitals, yet they provide 20 percent of all Medicare hospitalizations, 21 percent of all hospital care, 25 percent of all Medicaid in-patient days, and 35 percent of all charity care.
- *Medical Standby Capacity*: Teaching hospitals deliver primary and preventive care we all need every day, but they also provide trauma care, burn units, and intensive care we hope never to need.
- *Community Health and Health Equity*: Academic medical centers partner with local residents through community-based programs to address social determinants of health, such as lack of access to healthful food, safe housing, and transportation.

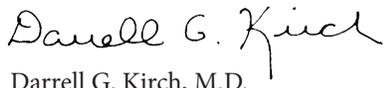
## Academic Medicine Faces Federal Policy Challenges

Our members face extraordinary policy challenges as they seek to fulfill their educational, scientific, and clinical care missions. This binder briefly outlines the current issues, recognizing that new ones will continue to arise. The most pressing are as follows:

- Advances in medical research require sustained, predictable increases in funding for NIH. Maintaining continued growth in NIH funding will enable researchers at medical schools and teaching hospitals to continue driving the innovation that improves health for all.
- Experts project a national doctor shortage of between 61,700 to 94,700 primary and specialty care physicians, in part due to a growing, aging population. Lifting the 1997 caps on Medicare graduate medical education (GME) support is a critical part of the solution.
- Medicare's indirect medical education (IME) payments are critical patient care payments that support Medicare's share of the costs teaching hospitals incur for treating the most complex patients. This funding must be preserved both to sustain an environment where teaching hospitals' training, patient care, and research missions can thrive and to support critical services vital to the health of our communities.
- Teaching hospital and medical school physicians treat a large proportion of our nation's most medically complex and vulnerable patients who frequently face challenges beyond a hospital's control. Medicare quality programs must take into account sociodemographic factors to ensure hospitals and physicians treating these patients are not penalized inappropriately.

The AAMC stands ready to aid you in improving and protecting the health of all Americans. Please contact AAMC Chief Public Policy Officer Karen Fisher, JD, any time at [kfisher@aamc.org](mailto:kfisher@aamc.org) or 202-828-0412.

Sincerely,



Darrell G. Kirch, M.D.  
President and CEO

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## ISSUE SUMMARY

Medical education promotes a commitment to learning across the professional lifespan to ensure physicians are prepared to respond to the country's changing health needs. At both the national level and at individual institutions, medical educators are implementing innovations across the continuum of education and training to reflect the changing context of patient care delivery.

### Issue

Over the last two decades, shifts in demographics, science, and federal policies have had a major impact on health care, a phenomenon that will persist. Accordingly, the education and training of physicians and other health professionals have changed significantly and continue to change. Initiatives are under way to enhance admissions processes, policies, and practices to better identify and select tomorrow's doctors for the health care system of the future. The structure, content, and delivery of medical education continues to be refined as medicine improves, new public health challenges emerge, learning and teaching are better understood, and educators strive to ensure more seamless transitions between the phases of medical education. These and other developments reflect the dynamic nature of health care and the corresponding commitment of medical education to prepare physicians that can adapt and respond to an ever-changing environment.

### Background

Following a highly selective admissions process, medical education is divided into three phases: medical school (undergraduate medical education), residency training (graduate medical education [GME]), and continuous education and improvement (continuing medical education).

Admissions committees at each medical school use broad-based selection criteria, including prior academic achievement and assessments, as well as evidence of the values and attitudes necessary to be an excellent and compassionate physician. Medical schools are testing new ways to consider personal characteristics, such as how well applicants work in teams, how they interact with diverse people, and their ability to be resilient, adapt to different situations, and think critically. Many medical schools use holistic review, a flexible, individualized way of assessing applicants' capabilities with balanced consideration of experiences, attributes, and academic metrics.

Recent changes to the AAMC-sponsored Medical College Admission Test® (MCAT®) added two new sections covering critical thinking as well as behavioral and social sciences, in addition to the existing content on biological sciences, physical sciences, and verbal reasoning, among other areas. Additionally, many institutions are implementing recruitment initiatives to address emerging national and local health care needs. According to a 2015 survey of all medical school deans, 84 percent of respondents reported specific admissions programs or policies designed to recruit a diverse student body interested in caring for underserved populations—including programs and policies geared toward minorities underrepresented in medicine, students from disadvantaged backgrounds, and students from rural and underserved communities.

Upon acceptance, students begin undergraduate medical education, usually four years. Medical education programs leading to an MD are accredited by the Liaison Committee on Medical Education (LCME), jointly sponsored by the AAMC and the American Medical Association and certified by the U.S. Department of Education. Each medical education program establishes a curriculum aligned with its own missions and educational objectives within the framework of general competencies required for LCME accreditation. Medical schools have centralized curriculum management and governance structures in a schoolwide executive committee with oversight responsibility. Traditionally, students receive grounding in the biomedical sciences and an introduction to basic clinical skills in the first two years, with required hands-on patient interactions via clinical rotations or clerkships in the last two years.

The content of medical student education is continually revised to reflect scientific advancements, medical breakthroughs, delivery-system changes, and social issues. For instance, the emphasis in medical care has shifted from treating acute conditions to managing more chronic illnesses, and physicians now increasingly treat problems related to aging. As a result, while maintaining a fundamental basic science and clinical curriculum, educators have modeled instruction around the management of chronic illness and have incorporated topics and themes such as geriatrics, pain management, palliative care, and others in the curriculum. Schools also include enhanced instruction on topics such as disease prevention and health promotion, population health, addiction, communication skills, social determinants of health, emergency preparedness, and medical informatics, among others.

The structure of medical school is also changing, with themes such as earlier clinical experiences, curricular structures integrating the basic and clinical sciences, emphasis on interprofessional educational opportunities, and case-based learning. Learners are exposed to a broad variety of health care settings and instructional modalities capitalizing on new technologies and capabilities. Increasingly, they are expected to achieve milestones in broad foundational domains of competency rather than merely amassing a litany of facts. And they have opportunities to better appreciate the societal and community factors that affect their patients' health. Schools are also reporting innovative approaches to advancing their specific missions, such as requiring students to complete nonmedical community service in the surrounding neighborhood, establishing dedicated tracks in primary care and rural health, promoting medical research experiences, or founding regional medical campuses at sites distant from the main campus.

Medical school graduates then must enter GME or residency training if they seek medical licensure and/or board certification in a medical specialty or subspecialty. This phase is conducted in clinical settings, with major teaching hospital systems training 74 percent of all residents. Residency programs vary in length depending on specialty but generally last three to seven years for initial board certification, while subspecialty training via fellowships may extend the GME period to as long as 11 years after students have received the MD. As part of their education, residents participate fully in the spectrum of diagnosis and treatment. However, residency is an educational program, and residents complete a multiyear period of learning in practice,

with gradually increasing responsibility and decreasing levels of faculty supervision, to gain competence and earn eligibility for unsupervised practice.

In GME, too, innovations abound. Educational experts are designing curricula and programs in response to community health needs. They are exploring opportunities to optimize the duration of GME by, for example, shortened educational pathways. An AAMC pilot project is currently testing the feasibility of moving away from a "one-size-fits-all" model of time-based advancement to competency-based advancement across the continuum from medical school through residency and practice. According to data from the Accreditation Council for Graduate Medical Education (ACGME), which includes the AAMC and four other organizations in its not-for-profit membership corporation, 88 percent of pipeline programs in both primary and nonprimary care specialties place residents in nonhospital and ambulatory settings for some of their training. And educators are reviewing the feasibility of holistic review for residency positions.

Aside from innovations in medical education, academic medicine is also at the forefront of leading innovations in medical discovery and health care delivery. Medical schools' and teaching hospitals' leadership in propelling such innovations goes hand in hand with the educational experience for the next generation of physicians. No environment is better suited and more committed to preparing the physician workforce for the health care system of the future than the very institutions pioneering such transformations. As new performance metrics are created, tested, and evaluated, these data will demonstrate the increasing ability of new physicians to work in teams, facilitate system changes to improve population health, and foster continuous quality improvement in care delivery.

After completing medical school and residency training, physicians must continue their professional development over the course of their careers. They do so in a variety of ways: by learning from their practice, by participating in educational activities, and by completing formal, institutionally sponsored continuing medical education. These experiences reinforce and update the content physicians studied in medical school and residency training and are essential for physicians to maintain board certification, to remain competent to practice medicine, to teach the next generation, and to provide the best quality of health care to their patients and communities.

## AAMC Policy Recommendation

- Policymakers should support the roles of medical schools and teaching hospitals as they train the next generation of physicians.

## Related Issues

- Health Professions Programs (Title VII)
- Diversity and Inclusion
- Physician Workforce Issues
- Medicare Mission Payments to Teaching Hospitals

## AAMC Contact

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## Web Resources

**Medical Schools Address Opioid Epidemic Through Innovations in Curricula and Other Methods**  
[www.aamc.org/opioidresponse](http://www.aamc.org/opioidresponse)

**Interprofessional Education Collaborative**  
[https://ipecollaborative.org/About\\_IPEC.html](https://ipecollaborative.org/About_IPEC.html)

**The Core Entrustable Professional Activities for Entering Residency**  
[www.aamc.org/initiatives/coreepas](http://www.aamc.org/initiatives/coreepas)

## ISSUE SUMMARY

The United States is facing a serious shortage of physicians, largely due to the growth and aging of the population and the impending retirements of older physicians. While medical schools are on pace to increase enrollment by 30 percent, the 1997 cap on Medicare support for graduate medical education (GME) has stymied commensurate increases in residency training, creating a bottleneck for the physician workforce.

In addition to raising the Medicare caps, support for non-GME physician workforce programs, such as the State Conrad 30 J-1 visa waiver, the National Health Service Corps (NHSC), and Title VII/VIII health professions training programs, can help recruit and retain physicians where they are needed most.

### Issue

An independent study commissioned by the AAMC projects a shortage of between 61,700 and 94,700 physicians by 2025, largely due to the growth and aging of the population and the impending retirements of older physicians. The impact of this shortage will disproportionately affect vulnerable and underserved populations in the United States. Currently, more than 60 million people live in rural or inner-city locations that have been designated as primary medical care health professional shortage areas. The nation needs more doctors and a more diverse workforce that is responsive to and capable of providing optimal care for our increasingly diverse population.

### Background

According to the U.S. Census Bureau, the nation grew by more than 27 million people in the most recent decade and the number of people over the age of 65 will double between 2000 and 2030. During that same period the number of people 80 and older will also increase dramatically: from 9.3 million in 2000 to 19.5 million in 2030. By 2056, for the first time in recorded history it is expected that the population aged 65 and older will exceed the size of the population under age 18. Over one-third of the current physician workforce is aged 55 or older and likely to retire in the coming decade. These changes will significantly increase demand for physicians' services. Patients aged 65 and older typically average six to seven medical visits per year compared with two to three visits annually for those under 65. Moreover, with advances in technology older adults are receiving care that might not have been possible even 10 years ago.

The nation is already feeling the strain of physician workforce shortages. For example, the Department of Veterans Affairs has experienced prolonged wait times for patient visits, and Indian Health Service physician vacancy rates persist in the 20 percent range due to a shortage of physicians. The Health Resources and Services Administration estimates that over 60 million individuals currently live in federally designated Health Professional Shortage Areas.

An independent study commissioned by the AAMC projects a shortage of between 61,700 and 94,700 physicians by 2025. Projected shortfalls in primary care range between 14,900 and 35,600 physicians, and projected shortfalls in nonprimary care specialties range between 37,400 and 60,300 physicians by 2025. If the physician pipeline is not increased, the U.S. physician workforce will be seriously challenged to meet the needs of a growing and aging nation. This shortage of physicians will profoundly affect access to health care, including longer waits for appointments and the need to travel farther to see a physician. Shortages can contribute to higher costs through increased use of emergency rooms and higher prices. They can reduce the quality of care if practitioners are overloaded or people delay getting services. Already, many areas of the country and a number of medical specialties—especially primary care and some of the surgical specialties—are reporting a scarcity of physicians. The elderly, the poor, rural residents, those who suffer from health and health care disparities, and the 20 percent of Americans who are already medically underserved will bear the brunt of these challenges.

In response to these challenges, the AAMC has called for a 30 percent increase in medical school enrollment and a commensurate increase in GME training positions. Although medical school enrollment is expected to reach the 30 percent goal by about 2017, this alone will not be sufficient to produce enough physicians to meet the needs and desires of the nation. Until the Medicare cap on residency funding is lifted, this growth in medical school enrollment will not be reflected in a proportionate increase in new physicians, as each medical school graduate needs to complete residency training before entering practice. In the 114th Congress, the AAMC endorsed legislation introduced in the House and Senate (H.R. 2124, S. 1148) that, as a first step, modestly raises the teaching hospital caps on Medicare GME support to produce about 3,000 more physicians per year.

Federal recruitment and retention programs help ensure a diverse and well-distributed physician workforce. For example, Titles VII and VIII education and training programs train providers in interdisciplinary settings to improve the supply and diversity of the physician workforce. The NHSC offers scholarships and loan repayment for U.S. primary care providers in underserved areas. International medical graduates also play an important role in the U.S. physician workforce, representing about a quarter of practicing physicians. The J-1 visa helps ensure a balanced physician immigration policy that prevents “brain drain,” while improving access in our nation’s underserved communities through programs like the State Conrad 30 J-1 Visa Waiver program. In the last decade alone, Conrad 30 has directed nearly 10,000 physicians into rural and urban underserved communities. All these programs are critical to helping ensure access to high-quality physician care.

### AAMC Policy Recommendations

- Increase the Medicare resident caps: The Medicare resident caps have been in place for 20 years. These caps limit the ability of teaching hospitals and medical schools to respond to the physician needs of their communities and the nation.
- Support non-GME incentives and programs: These incentives and programs, including Conrad 30, the NHSC, and Title VII/VIII, are used to recruit a diverse workforce and encourage physicians to practice in shortage specialties and underserved communities.

### Related Issues

- Health Professions Programs (Title VII)
- Public Service Programs
- Diversity and Inclusion
- Research Training and Workforce
- Medicare Mission Payments to Teaching Hospitals
- Medicaid and the Children’s Health Insurance Program
- Medicare Physician Payment and Quality
- Alternative Payment Models

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### Web Resources

#### AAMC Workforce Studies

[www.aamc.org/data/workforce](http://www.aamc.org/data/workforce)

#### Physician Shortage and Projections

[www.aamc.org/data/workforce/reports/439206/physicianshortageandprojections.html](http://www.aamc.org/data/workforce/reports/439206/physicianshortageandprojections.html)

#### Medicare GME Funding: How to Fix the Doctor Shortage

[www.aamc.org/newsroom/keyissues/physician\\_workforce](http://www.aamc.org/newsroom/keyissues/physician_workforce)

#### Optimizing Graduate Medical Education

[www.aamc.org/initiatives/optimizinggme](http://www.aamc.org/initiatives/optimizinggme)

## ISSUE SUMMARY

While medical education is an excellent investment, federal financial aid programs are critically important to helping ensure medical school remains affordable for students from all backgrounds. The AAMC is deeply concerned with an ongoing federal trend of cutting graduate and professional (“grad/prof”) student aid. The upcoming reauthorization of the Higher Education Act (HEA) is an opportunity to improve financial aid for medical students, as well as remove administrative and regulatory burdens for medical schools.

### Issue

There is a growing disparity between undergraduate and grad/prof education policy, such as in the Public Service Loan Forgiveness (PSLF) program and student loans. Any changes in the HEA reauthorization must recognize the unique aspects of medical education, including higher costs of attendance and residency training necessary for licensure and practice. Congress should use HEA reauthorization to ensure that the Department of Education’s state authorization, gainful employment, and postsecondary institution ratings system regulations appropriately account for the differences in medical education.

In 2015, the typical medical school graduating debt was \$183,000. Depending on the federal repayment plan and length of medical residency, expected total repayment amounts range from \$329,000 to \$480,000. While student debt can be a significant burden to some graduates, AAMC analysis and surveys have found that, on the whole, educational debt seems to have relatively little influence on specialty choice. Nonfinancial factors such as personal interest in a specialty’s content and/or level of patient care seem to have more influence on specialty choice.

Additionally, nationwide physician workforce shortages have put added pressures on medical schools and the medical student pipeline. With decreasing state financial support, it is important for Congress to ensure that the HEA reauthorization helps keep medical education affordable for students from all backgrounds and that medical education debt does not become an insurmountable burden in the future.

### Background

In recent years, policymakers have proposed several cuts to grad/prof student aid that hurt medical students and jeopardize the affordability of medical education:

- The Obama administration’s budget proposed capping PSLF at undergraduate levels, costing medical students over \$100,000 in loan forgiveness.
- The Department of Education revised the Pay as You Earn (PAYE) program so that grad/prof students have an extra five years of repayment before they are eligible for forgiveness compared with the repayment time for undergraduates.
- Congress eliminated the grad/prof Stafford loan subsidy, increasing total repayment for medical students between \$10,000 and \$20,000.
- Grad/prof interest rates are 1.55 percentage points (approximately 40 percent) higher than interest loans for undergraduate loans, despite the higher education costs and lower default rates of medical students.

The PSLF program forgives federal student loan debt for physicians that practice at government or nonprofit facilities for 10 years—the longest obligation for a federal public service program for physicians. Unlike other safety net repayment programs, which were designed to protect students, PSLF was established to help meet the country’s public service needs. Since its creation, medical students have reported increased interest in participating in PSLF at facilities like teaching hospitals that provide a disproportionate share of charity and Medicare/Medicaid patient care.

As originally defined under the PSLF program, public service includes “public health”; the program description specifically lists, for example, “full-time professionals engaged in health care practitioner occupations and health care support occupations.” In medicine, public service can include both primary care and specialty disciplines—family medicine physicians at community health centers, emergency medicine physicians at inner-city hospitals, or surgeons at Department of Veterans Affairs (VA) medical centers. By 2025, the AAMC projects a shortfall of between 14,900 and 35,600 primary care physicians and between 37,400 and 60,300 in other physician specialties.

The Obama administration’s proposed cap for PSLF at undergraduate levels unnecessarily limits physicians’ ability to participate in this new program. The higher cost of graduate and professional repayment benefits is underwritten by higher interest rates, unsubsidized loans, and income-driven repayment. As a result, physicians inequitably repay more per dollar borrowed than undergraduates, despite higher debts and lower default rates. Public service also should not be defined by income level. To be effective within any given occupation, incentives to pursue public service must be proportional to the income differential between the private and public sectors.

### AAMC Policy Recommendations

- In line with recommendations of the National Association of Student Financial Aid Administrators (NASFAA), the AAMC urges any cap on forgiveness to be at least the aggregate graduate and professional student loan limit—\$224,000 for physicians. The AAMC opposes capping PSLF in a manner that categorically or effectively excludes physicians or specific specialties.
- The AAMC opposes eliminating the grad/prof PLUS loan and capping federal loan limits at less than the full cost of attendance, which would force many medical students to take out private loans with less-favorable terms.
- The AAMC supports reducing interest rates and reinstating the graduate and professional in-school interest subsidy to match undergraduate loan terms and simplify the student aid system.
- The AAMC encourages simplifying the Free Application for Federal Student Aid (FAFSA) and consolidating income-driven repayment plans to reduce unnecessary complexity.

### Related Issue

- Public Service Programs

### AAMC Contact

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### Web Resources

#### Student Aid Alliance

<http://act.studentaidalliance.org>

#### AAMC’s FIRST (Financial Information, Resources, Services, and Tools) Program

[www.aamc.org/first](http://www.aamc.org/first)

#### Medical Student Education: Debt, Costs, and Loan Repayment Fact Card

[www.aamc.org/download/447254/data/debtfactcard.pdf](http://www.aamc.org/download/447254/data/debtfactcard.pdf)

#### Physician Education Debt and the Cost to Attend Medical School: 2012 Update

<https://members.aamc.org/eweb/upload/Physician%20Education%20Debt%20and%20the%20Cost%20to%20Attend%20Medical%20School,%202012%20Update.pdf>

## ISSUE SUMMARY

Federal health professions education and training programs play a critical role in developing a workforce that meets the nation's changing health care needs. The AAMC supports increased funding for the workforce development programs authorized under Title VII (physicians and other health professions) and Title VIII (nursing) of the Public Health Service Act.

### Issue

The Title VII and VIII education and training programs of the Public Health Service Act (42 USC 292 et seq.) are the only federal programs with the stated goal of training providers in interdisciplinary settings to improve the supply, diversity, and distribution of the physician and health professions workforce. The Title VII programs have suffered from chronic underfunding in recent years due to the constrained budget environment. The Title VII programs need a strong and stable investment from year to year as part of a comprehensive national workforce strategy to meet the country's growing health care needs.

### Background

The U.S. population is aging with the baby boomer generation, resulting in higher per capita consumption of health care and increased physician retirement. It is essential to ensure an adequate supply of well-trained providers to address this added strain on the health care workforce. Because the Title VII health professions programs emphasize diversity, primary care, and special-need or underserved populations, increased support for these programs is critical to achieving this goal.

Title VII and Title VIII authorize, respectively, the health professions and nursing workforce programs administered by the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services (HHS). Through loans and scholarships to students, as well as grants and contracts to academic institutions and nonprofit organizations, these programs support the education and training of health care providers, including physicians, dentists, pharmacists, nurses, psychologists, and public and allied health professionals.

Designed to improve the supply, diversity, and distribution of the health care workforce, Title VII programs pick up where traditional market forces leave off. For example, the Title VII diversity programs increase racial and ethnic minority representation in the health professions by providing academic enrichment and career development. Centers of Excellence implement programs to improve clinical education, curricula, and cultural competence. The Health Careers Opportunity Program (HCOP) is a K–16 pipeline program that partners with local educational and community organizations to improve the recruitment and retention of minority and disadvantaged students in the health professions workforce.

Similarly, the Primary Care Training and Enhancement Program helps expand the primary care workforce, and the Area Health Education Centers facilitate community-based linkages and training in underserved rural and urban areas. By assessing the needs of the communities they serve, the Title VII geriatric and pediatric programs are well positioned to fill workforce gaps and increase access to care for all populations. Further, the programs emphasize interprofessional education and training, bringing together knowledge and skills across disciplines to provide effective, efficient, and coordinated care.

With the country's current and expected health workforce shortages, Title VII will become more important in the country's effort to develop a diverse and culturally competent workforce that is distributed across rural and underserved communities. The Title VII physician and health professions programs are an essential component of the health care safety net, training a diverse supply of providers who are more likely to serve in rural and underserved settings and in community health centers. A continued commitment to and strong investment in the health professions programs are needed to ensure that these programs are well positioned to meet the growing demand for health care professionals.

## AAMC Policy Recommendations

- As a founding member of the Health Professions and Nursing Education Coalition (HPNEC), the AAMC recommends increased funding for Title VII and Title VIII that will ensure the programs can both educate and train professionals to help meet the ever-growing demand for care.
- The AAMC continues to recommend that Congress and the administration prioritize the development of racial and ethnic minority faculty across the health professions. The Title VII diversity programs are critical to the development of the racial and ethnic minority health care workforce, as these mentors create a supportive environment that allows diverse health professions students to thrive as future providers.
- The AAMC recommends that HHS use its authority to increase grant awards for Title VII programs to support data collection, tracking, and long-term program evaluation. These activities will need an adequate investment from Congress to be effective.

## Related Issues

- Physician Workforce Issues
- Diversity and Inclusion
- Health Equity

## AAMC Contact

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## Web Resources

### **Health Professions and Nursing Education Coalition Updates**

[www.aamc.org/advocacy/hpniec](http://www.aamc.org/advocacy/hpniec)

### **Health Professions and Nursing Education Programs FY 2017 Brochure**

[www.aamc.org/advocacy/hpniec/FY2017HPNECBrochure.pdf](http://www.aamc.org/advocacy/hpniec/FY2017HPNECBrochure.pdf)

### **Health Resources and Services Administration Health Workforce Information**

<http://bhpr.hrsa.gov>

## ISSUE SUMMARY

To help address physician workforce shortages, federal programs such as the National Health Service Corps (NHSC) and Public Service Loan Forgiveness (PSLF) provide important incentives to recruit and retain physicians in underserved areas. The AAMC supports increasing federal investment without restricting physician eligibility for programs to improve vulnerable communities' access to health care.

### Issue

The AAMC projects a nationwide shortage of physicians of between 61,700 and 94,700 by 2025, with a significant shortage in many surgical specialties. The independent study conducted on behalf of the AAMC estimates a shortfall of between 14,900 and 35,600 primary care physicians. Nonprimary care specialties are expected to experience a shortfall of between 37,400 and 60,300 physicians.

Though these shortfalls will affect all Americans, the most vulnerable populations in underserved areas will be the first to feel the impact (e.g., patients of the Veterans Health Administration, Medicare and Medicaid patients at nonprofit teaching hospitals, patients of rural and urban community health centers, and American Indians and Alaska Natives).

While medical education remains an excellent investment, the typical graduating debt of medical students exceeds \$180,000. Several targeted federal public service programs provide critical incentives through loan repayment and forgiveness to recruit and retain physicians who help meet the unique health care needs of these underserved communities.

### Background

The NHSC provides scholarships and loan repayment for physicians (among other health professions) who practice primary care in federally designated Health Professions Shortage Areas (HPSAs). With a field strength of 9,683 in 2015, including 2,290 physicians, more than 10 million patients relied on NHSC providers for health care.

Despite the NHSC's success, it still falls far short of fulfilling the health care needs of all HPSAs due to growing demand for health professionals across the country. The Health Resources and Services Administration (HRSA) estimates that 7,900 additional primary care physicians are required to eliminate all primary care HPSAs. In more tangible terms,

the current practitioner deficit results in 60 million unserved primary care patients living within underserved areas spread across every state. The NHSC is currently financed through a \$310 million per year mandatory fund that expires at the end of fiscal year 2017.

The Department of Education's PSLF program forgives federal student loan debt for physicians that practice at government or nonprofit facilities for 10 years—the longest obligation for a federal public service program for physicians. Unlike other safety net repayment programs, which were designed to protect students, PSLF was established to help meet the country's public service needs.

Since the creation of the PSLF program, medical students have reported increased interest in participating in this program at facilities like teaching hospitals that provide a disproportionate share of charity and Medicare/Medicaid patient care. In 2016, the president's budget proposed capping PSLF at the \$57,500 undergraduate level, limiting physicians' ability to participate.

Other important federal programs that help recruit and retain physicians to public service include the following:

- The Veterans Health Administration Education Debt Reduction Program (EDRP)
- The Indian Health Service
- U.S. Military Health Professions Loan Repayment Programs
- The National Institutes of Health (NIH) Loan Repayment Program

Each of these programs serves a specific targeted purpose and/or population and is critical to addressing physician workforce distribution to meet the unique health needs across the country.

### AAMC Policy Recommendations

- The AAMC supports significantly increasing the financial investment in the NHSC, including restoring annual appropriations for the program rather than fully relying on the NHSC mandatory fund that faces periodic fiscal cliffs and requires funding offsets.
- In line with recommendations of the National Association of Student Financial Aid Administrators (NASFAA), the AAMC urges any cap on forgiveness to be at least the aggregate graduate and professional student loan limit—\$224,000 for physicians. The AAMC opposes capping PSLF in a manner that categorically or effectively excludes physicians or specific specialties.
- The AAMC encourages a wide breadth of targeted federal public service programs to help meet the health care needs of the country and of specific vulnerable populations.

### Related Issues

- Physician Workforce Issues
- Higher Education Act Reauthorization
- Caring for Our Nation's Veterans

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### Web Resources

**March 2015 Letter from NHSC Stakeholders to Congress**

[www.aamc.org/download/428158/data/nhscstakeholdersurgef2016appropriation.pdf](http://www.aamc.org/download/428158/data/nhscstakeholdersurgef2016appropriation.pdf)

**AAMC's Database on State and Federal Loan Repayment/Forgiveness Scholarship Programs**

[www.aamc.org/stloan](http://www.aamc.org/stloan)

**Summary of the PSLF Program**

<https://students-residents.aamc.org/financial-aid/article/public-service-loan-forgiveness-pslf/>

**The National Health Service Corps**

<http://nhsc.hrsa.gov>

## ISSUE SUMMARY

With the nation's population growing and becoming increasingly diverse, it is crucial that the physician workforce reflect the changing demographics of the country to mitigate racial, ethnic, and socioeconomic health disparities. The AAMC supports several public and private efforts, such as Title VII workforce training programs and Deferred Action for Childhood Arrivals (DACA) status, that aid in diversifying the health care workforce to meet the health care needs of different communities.

### Issue

Since the passage of the Affordable Care Act, millions of Americans are accessing health care for the first time. It is important that medical schools and teaching hospitals produce a racially and ethnically diverse and culturally responsive health care workforce to meet the health care needs of underserved populations, improve cultural awareness, and eliminate health disparities. Supporting the efforts of medical schools and teaching hospitals to improve the diversity of the physician workforce are fundamental to achieving better health for all.

### Background

A diverse workforce is necessary for improving patient care and health outcomes, especially for the sizable U.S. minority population disproportionately affected by health disparities. The U.S. population is projected to become a majority-minority in 2044, thereby increasing the need to prepare and train health care professionals who are culturally responsive and equipped to provide quality care in a multicultural society. Diversity in the health professions leads to improvements in access to care for the underserved, better quality of care, and learning environments that increase creativity and innovation for all students. The composition of the current physician workforce indicates that only about 9 percent of physicians identify as black or African-American, American Indian or Alaska Native, and Hispanic or Latino, which is not representative of the nation's demographic shift. Minority scientists are also significantly underrepresented in the research workforce. For example, a 2012 report from the National Institutes of Health (NIH) indicates that only 1.1 percent of NIH principal investigators on research project grants in 2010 were black or African-American. Creating educational opportunities that help develop a physician and scientist workforce that is reflective of the needs of and responsive to the needs of diverse populations is critical to advancing health equity.

Studies have demonstrated how effective pipeline programs, such as the Health Careers Opportunity Program (HCOP) and the Summer Medical and Dental Education Program, are in strengthening students' academic records, improving test scores, and helping minority and disadvantaged students become more competitive applicants for health professions training programs. Title VII health professions programs, such as Centers of Excellence (COE) and HCOP, are critical federal investments in diversifying the health care workforce. HCOP is a K–16 pipeline program that partners with local educational and community organizations to improve the recruitment and retention of minority and disadvantaged students in the health professions workforce. The AAMC report, *Altering the Course: Black Males in Medicine*, highlighted the decline of black males applying for medical school, which is why pipeline programs, such as HCOP, play a critical role in diversifying the physician workforce. COEs support increased research on minority health, establish educational pipelines, and provide clinical experiences in community-based health facilities.

In 2016, the Supreme Court closed an eight-year chapter of uncertainty by upholding the constitutionality of considering race in admissions under *Fisher v. University of Texas at Austin*. The court's decision reaffirms the educational benefits of diversity and defers to the good-faith judgments of educators who strive to achieve those benefits for their students and for society as a whole. The decision embraces the notion of diversity as multi-dimensional and bolsters the use of individualized, holistic review in admissions, based on each school's mission and circumstances. In light of this decision, U.S. medical schools may continue their institution-specific efforts both to ensure that graduating physicians are prepared to practice medicine in an increasingly diverse society and to address the disparities that exist in today's health care system.

According to an annual survey of all medical school deans, in 2015, 84 percent of respondents reported specific admissions programs or policies designed to recruit a diverse student body interested in caring for underserved populations—including programs and policies geared toward minorities underrepresented in medicine, students from disadvantaged backgrounds, and students from rural and underserved communities.

For certain undocumented immigrants, DACA grants lawful presence in the United States, work authorization, Social Security numbers, and, in many cases, state IDs and driver's licenses, all of which make application to medical school and residency training possible. Students with DACA status represent a diverse, multicultural, multiethnic population, who are often bilingual and likely to return to practice in medicine in underserved communities. In 2014, the AAMC expanded its Fee Assistance Program (FAP) for the Medical College Admission Test® (MCAT®) and the American Medical College Application Service® (AMCAS®) to students with DACA status. Despite the opening of these doors, DACA students frequently identify as economically disadvantaged and cite ineligibility for federal financial aid as one of the biggest barriers to attending medical school.

### AAMC Policy Recommendations

- The federal government should continue supporting efforts to diversify the health care workforce by providing continued and adequate funding for the Title VII health professions programs, such as COEs, HCOP, and Scholarships for Disadvantaged Students.
- The AAMC supports the consideration of race in admissions under holistic review to help ensure a diverse workforce to address health disparities.
- The AAMC supports expanding eligibility of federal financial aid to students with DACA status.

### Related Issues

- Physician Workforce Issues
- Health Equity

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### Web Resources

#### **AAMC's Resources and Inspiration for Aspiring Docs**

<https://students-residents.aamc.org/choosing-medical-career/medical-careers/aspiring-docs>

#### **Summer Health Professions Education Program**

<http://shpep.org/>

#### **AAMC's Diversity and Inclusion Resources**

[www.aamc.org/initiatives/diversity](http://www.aamc.org/initiatives/diversity)

#### **AAMC's Discussion of Holistic Review**

[www.aamc.org/initiatives/holisticreview](http://www.aamc.org/initiatives/holisticreview)

#### **AAMC Publication: *Altering the Course: Black Males in Medicine***

[www.aamc.org/blackmalesinmed](http://www.aamc.org/blackmalesinmed)

## ISSUE SUMMARY

The partnership between the National Institutes of Health (NIH) and the nation's medical schools and teaching hospitals, forged just after World War II, has led to a deeper understanding of the mechanisms of human health and disease and has provided better diagnostics, treatments, cures, and ways to improve health and save lives. Continued advances require sustaining robust, predictable increases in the NIH budget.

### Issue

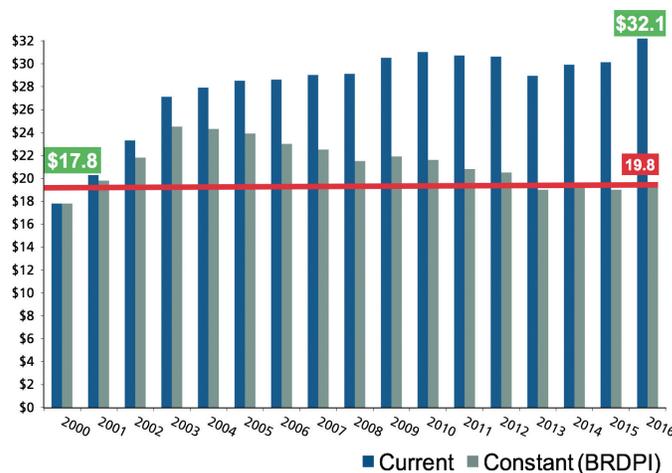
NIH is the nation's largest medical research agency and a leading source of research support at medical schools and teaching hospitals. NIH-funded research has led to advances in treating cancer, declining death rates from heart disease and stroke, and extended survival for persons with HIV/AIDS. Such research requires adequate, sustained funding over many years. Support for medical research is, therefore, a long-term investment. Thousands of organizations supported by NIH, including medical schools, universities, teaching hospitals and health systems, research institutes, and small businesses, are partners in the biomedical research system, also investing from their own internal resources to maintain their cutting-edge research. Though strong bipartisan support in Congress has led to significant recent funding increases, NIH's budget—adjusted for inflation—remains lower than it was a decade ago, while the health challenges and complexity of medical research have increased. Continuing the momentum of these recent investments will enable researchers at medical schools and teaching hospitals to continue driving the innovation that improves health for all.

### Background

With an annual budget of \$32.1 billion (fiscal year [FY] 2016), NIH is the primary source of federal funding for medical research. NIH research funding is divided between intramural research (conducted by NIH employees at NIH facilities) and extramural research (mostly conducted at academic medical centers, universities, and independent research institutes). Approximately half of NIH's extramural funds supports research by distinguished physicians and scientists at U.S. medical schools and teaching hospitals. These researchers apply for NIH funding through an intensely competitive peer-review process that funds only the most promising and highest-quality research. Today, NIH receives about 90,000 grant applications a year, with fewer than one in six receiving support through its extramural research program.

Funding the NIH budget, and thus continuing the support NIH provides to the nation's leading researchers, is a critical priority for Congress. With bipartisan support, the NIH budget doubled in the period from FY 1999–2003. However, after the doubling, NIH's base budget has failed to keep pace with biomedical inflation (known as the Biomedical Research and Development Price Index or BRDPI). Since FY 2003, a combination of nominal increases and cuts has resulted in a stagnant budget base leading to a 20 percent decline in the agency's purchasing power and has undermined the strengthened research potential and accomplishments enabled by the doubling.

NIH FUNDING FYs 2000–2016 (\$ IN BILLIONS)



Sources: NIH Budget Office; House and Senate Appropriations Committees

The current probability that less than 15 percent of new NIH grant proposals will be funded is especially worrying as it discourages new trainees who represent the next generation of our research workforce. The scientific pipeline is in serious danger of breaking as new investigators struggle to find support for their research. In the face of declining paylines from NIH, institutions must also invest their own resources to sustain their research programs. A recent AAMC study

found that academic medical centers, on average, invest 53 cents for every dollar of externally sponsored support, including NIH support, in an effort to keep pace with existing costs.

Over the past 30 years, our nation's investment in medical research through NIH has amounted to about \$75 per American per year. But the return on this investment has been truly spectacular, with an increase in life expectancy and a decrease in deaths from many chronic and infectious diseases. Yet today, we are still spending far more to treat disease and disability than we do to prevent or cure it. Total U.S. health care spending, currently more than \$3.0 trillion, is more than 90 times the NIH budget.

NIH has also launched a series of new initiatives meant to accelerate our understanding of human health and disease. The Precision Medicine Initiative, started in 2015, is an effort to create a data-driven enterprise by engaging a million citizens in a large-scale research cohort. NIH is heavily engaged in the Cancer Moonshot to speed progress in cancer treatment and care. The Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative, started in 2014, has already made a significant contribution to our understanding of the human brain.

To further advance its mission and enhance decision making, NIH, at the request of Congress, recently released a five-year agencywide strategic plan to serve as a framework for the most effective use of its resources. Because NIH funds research to address critical gaps in the basic biomedical and behavioral sciences that have the potential to catapult fields forward and speed the translation of basic discoveries into improved health, we must ensure predictable and sustainable funding to maintain the biomedical research enterprise.

### AAMC Policy Recommendations

- The AAMC strongly supports sustained, predictable growth in NIH funding. The AAMC is cognizant of our responsibility to work with the Administration and Congress to balance the many interests of our constituents, while acknowledging the long-term fiscal challenges faced by the nation.
- NIH Director Francis Collins has testified that “a stable trajectory of inflation plus 5 percent for multiple years” could optimally support medical research. Thus, in FY 2017 the AAMC and the Ad Hoc Group for Medical Research recommended an increase of at least 5 percent above the

level of inflation for NIH's FY 2017 appropriation. As appropriators worked to finalize the FY 17 spending bills, the AAMC and the Ad Hoc Group urged Congress to adopt the Senate Appropriations Committee–approved level of \$34.1 billion for NIH in the final spending package.

- The AAMC also commends efforts by NIH's congressional authorizers to reform key elements of the medical research system, especially with regard to reducing and streamlining regulatory burden so that resources can be used more efficiently; fostering more strategic coordination across institutes and centers in pursuing research objectives; ensuring the vitality of future generations of medical researchers, including physician scientists; and exploring innovative opportunities to supplement NIH's annual budget with new long-term investments in targeted areas.

### Related Issues

- Other Priority Health and Research Agencies
- Agency for Healthcare Research and Quality
- Research Training and Workforce
- Research Regulatory Burden

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### Web Resources

**AAMC Information on Medical Research**  
[www.aamc.org/initiatives/research](http://www.aamc.org/initiatives/research)

**AAMC's Research Means Hope Campaign**  
<http://medresearch.tumblr.com>

## ISSUE SUMMARY

The ability to maintain a productive, innovative, and multidisciplinary scientific and medical research workforce depends on the success of academic institutions in training, recruiting, and retaining talented and dedicated scientists. Our future progress in research is dependent on research careers remaining an attractive and viable option for new generations of physicians and biomedical scientists.

### Issue

In addition to training the nation's physicians, academic medical centers train the majority of biomedical scientists in the United States. There are multiple training pathways for pursuing a career in medical research (MD, MD/PhD, or PhD), each of which contributes to building a diverse research workforce. While scientists pursue various careers that contribute to the research enterprise, it has become difficult for those who wish to pursue academic research careers to obtain permanent positions. The average age at which scientists receive their first federal independent research award is increasing (currently 42, 44, and 45 for PhD, MD/PhD, and MD recipients, respectively). This environment has led to research trainees becoming discouraged about their prospects for careers in research.

### Background

Annually, more than 9,000 students earn PhDs in biological and medical sciences at U.S. institutions. Students generally receive tuition support, benefits, and stipends throughout their graduate training. Many trainees wishing to pursue research careers engage in postdoctoral training to gain the full complement of skills required for independent research careers. More than 100 dual-degree (MD/PhD) training programs, of which 45 are currently funded by the National Institutes of Health (NIH) Medical Scientist Training Program (MSTP), produce over 600 MD/PhD graduates each year. Those pursuing an MD receive research training in multiple ways—for example, through mentored research experiences during medical school, medical student enrichment year opportunities, and research experiences during residency training.

Biomedical PhD graduate training is mainly supported by NIH and other federal research grants, fellowships, and traineeships as well as from institutional funds. Biomedical graduate education has an enormous value to society, not only through the development of researchers, but also in the training of scientists who can apply analytic methods and critical thinking to a number of different jobs and sectors to support the research enterprise as a whole. Career paths taken by biomedical science PhDs include research across a variety of sectors, academic administration, law/policy, consulting, and writing. To address these trends, training programs are expanding their focus on data analysis, team science and collaborative research, and collecting more comprehensive information on training outcomes. In addition, the NIH Broadening Experiences in Scientific Training (BEST) program is supporting the development and dissemination of institutional career development training practices.

Over the last 40 years, the number of students supported through federal research grants and fellowships has almost tripled. However, the NIH training budget has remained largely flat since 2004. In 2001, in response to a report from the National Research Council, *Addressing the Nation's Changing Needs for Biomedical Scientists* (2000), NIH expressed the importance of increasing stipends for graduate students and postdoctoral trainees supported under the National Research Service Award (NRSA) to reflect the high level of education and professional skills involved in biomedical research. However, for many years, those stipend levels remained flat or had small increases of only 1 or 2 percent. In response to the 2016 Department of Labor Overtime Final Rule under the Fair Labor Standards Act, NIH announced that it would increase the awards for postdoctoral NRSA recipients to levels above the new salary threshold.

Physician scientists who want to pursue research careers face some unique challenges. Unlike the pathway for PhD trainees, the training pathway for physician-scientists is not as clearly defined. However, there is an increasing prominence of early, well-structured training in basic science and clinical research in medical school curricula that includes the option to take one or more years to complete research projects. The risk remains that new physician scientists who want to pursue academic research careers will be unable to secure funding from NIH and will be drawn to more stable, well-paid job opportunities in private practice, thus decreasing the small pool of trained physician scientists.

Maintaining a diverse academic research workforce continues to be a challenge. Although half of U.S. medical students and new biomedical PhDs are women, women continue to be underrepresented in the academic research workforce, particularly in leadership positions. Minority scientists are also significantly underrepresented in both the training pipeline and the research workforce. For example, a 2012 report from NIH indicates that only 1.1 percent of NIH principal investigators on research project grants in 2010 were black or African-American. Close collaboration between the member institutions of the AAMC, NIH, and other stakeholders is essential for developing strategies to promote a more diverse research workforce. The AAMC is supportive of the new NIH initiatives to enhance the diversity of the NIH-funded workforce: Building Infrastructure Leading to Diversity (BUILD), the National Research Mentoring Network (NRMN), and the Coordination and Evaluation Center (CEC).

### AAMC Policy Recommendations

- The federal government must expand funding for NIH and other Department of Health and Human Services (HHS) agency grants to strengthen the research workforce. Sustained growth in the overall NIH budget would permit increases in the training budget and stipend levels.
- The AAMC and its member institutions strongly support high-quality education and training for a diverse medical research workforce that includes supportive mentoring, effective career guidance, and adequate financial support for all research trainees, as well as help in cultivating relevant skills.

### Related Issues

- National Institutes of Health
- Diversity and Inclusion
- Physician Workforce Issues

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### Web Resource

#### **AAMC Information on Medical Research**

[www.aamc.org/initiatives/research](http://www.aamc.org/initiatives/research)

## ISSUE SUMMARY

The design and conduct of ethical research with human subjects is essential to scientific and medical progress to improve the lives and health of all. Recent efforts to update and rethink the regulations concerning federal oversight of human subject research present significant opportunities and challenges, as the relevant agencies have revisited these rules for the first time in 25 years. Proposals to redefine “human subject” and change the nation’s approach to conducting research on biospecimens could dramatically increase institutional burden and stifle research without an appreciable increase in providing individuals with meaningful information or choice about their participation in research.

### Issue

Research with human subjects is an essential driver of scientific progress that improves health and medical care, from interviews and surveys in the social sciences to clinical trials that evaluate the safety and efficacy of drugs and devices. The cornerstone of this research is its ethical conduct, which requires not only that the research itself is ethical, but that its conduct reflects a respect for the individual participants in that research. The regulatory framework for the oversight of research with human subjects, known as the “Common Rule,” is based on sound ethical principles but was last updated 25 years ago. The design and conduct of research has changed in the ensuing years, in the settings where research occurs; the volume of data collected, used, and shared; the technology employed; and the level of public engagement in and understanding of research. The Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking to revise the Common Rule in September 2015, and the AAMC, along with numerous other stakeholders, provided extensive comments on the proposed approach.

### Background

In 1979, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research released the landmark Belmont Report, which set forth three basic principles for research with human subjects: respect for persons, beneficence, and justice. Respect for persons is the obligation for researchers to treat individuals as autonomous agents capable of self-determination and to protect those lacking this capacity; the principle of beneficence is the duty to minimize harm and maximize benefits, both at the individual and societal levels; and justice refers to the fair distribution of the benefits and burdens of the research process, considering the question of who ought to enjoy the benefits of research and who ought to bear its burdens.

With its ethical foundation firmly rooted in the principles of the Belmont Report, the Common Rule provides the regulatory requirements for research involving human subjects that is funded or overseen by the 15 federal agencies that concurrently adopted it, from the National Aeronautics and Space Administration to the Environmental Protection Agency. Research subject to the Common Rule must undergo ethical review by an Institutional Review Board (IRB).

In 2011, the Office of the Secretary of Health and Human Services, with the Office of Science and Technology Policy in the Executive Office of the President, began the process of revising the rule. The revision process stems from broad consensus that the decades-old regulations were not adequate for the interconnected and advanced research landscape of today. Due to advances such as genetic sequencing, bioinformatics, and “big data” analysis, the capacity to conduct new types of research has been greatly expanded, and the dividing line between research and care delivery in a learning health care system is less clear.

Since July 2011, when an Advance Notice of Proposed Rulemaking (ANPRM) was published indicating HHS's intention to revise the Common Rule, the broad research community has been actively engaged in this process. There were over 1,000 public comments to the ANPRM, and after the subsequent September 2015 Notice of Proposed Rulemaking (NPRM), HHS received over 2,000 comments, many critical of the proposed approach.

Concerns about the proposed revisions to the Common Rule focused on the change to the definition of "human subject" to include biospecimens (biological materials taken from the body such as blood or tissue), even those without any associated data about the individual from whom those specimens were obtained. This represents a fundamental shift in how research with unidentified biospecimens is now conducted and would potentially increase the complexity and cost of this critical research significantly without a commensurate benefit for or increased information to individuals.

On June 29, 2016, the National Academies of Sciences, Engineering, and Medicine (National Academies) released the second part of a report titled *Optimizing the Nation's Investment in Academic Research: A New Regulatory Framework for the 21st Century*. In this congressionally requested report, the National Academies recommended the immediate withdrawal of the proposed rule and the creation of a new national commission to recommend to the president, Congress, and the federal agencies "how the basic ethical principles governing human subjects research should be applied to unresolved human research questions and novel human research contexts."

### AAMC Policy Recommendations

- The AAMC and its members are wholly committed to ensuring that research with human subjects is designed and conducted in an ethical manner with appropriate institutional and federal oversight and agrees that the regulatory framework for this oversight should be firmly grounded in sound ethical principles.
- The AAMC disagrees with proposals to define research with de-identified biospecimens as human subject research and to require all individuals whose biospecimens might be used in future research to sign a generic "broad consent" document. Instead, the AAMC proposes the creation of a "robust notification" requirement, which would require institutions to give individuals access to important information about how their biospecimens might facilitate research to advance medical knowledge and treatment.
- As described in its January 2016 comments on the proposed changes to the Common Rule, the AAMC continues to urge HHS to substantially revise the proposal and take advantage of the "unique opportunity to reframe and modernize the Common Rule and to capture the promise and potential of research breakthroughs while recognizing that individuals want to understand the commitments and contributions they are making to move science and health forward."

### Related Issue

- Research Regulatory Burden

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### Web Resources

#### AAMC Resources on the Common Rule

[www.aamc.org/commonrule](http://www.aamc.org/commonrule)

#### The Office for Human Research Protections

[www.hhs.gov/ohrp](http://www.hhs.gov/ohrp)

#### Optimizing the Nation's Investment in Academic Research: A New Regulatory Framework for the 21st Century

[www.nap.edu/catalog/21824/optimizing-the-nations-investment-in-academic-research-a-new-regulatory](http://www.nap.edu/catalog/21824/optimizing-the-nations-investment-in-academic-research-a-new-regulatory)

## ISSUE SUMMARY

The cumulative effect of federal regulations and reporting requirements places significant stress on institutions and individual researchers that can impede research productivity and innovation. As recommended by the National Academies of Sciences, Engineering, and Medicine (National Academies), the AAMC strongly supports initiatives to reduce, streamline, and harmonize regulations and recommends a prospective evidenced-based review of specific regulations before they are finalized to ensure that the burden imposed by the regulation is justified.

### Issue

Medical research conducted at institutions across the United States fuels economic prosperity, fosters innovation, and contributes to public health. At the same time, research institutions must comply with federal regulations and policies. While federal oversight of medical research is essential for a regulatory system that ensures objectivity, integrity, and accountability, the unintended cumulative effect of federal regulations places significant stress on institutions and individual researchers. Without careful review and the ability to revisit ineffective or outdated requirements, federal regulations and reporting requirements will increase and can impede research productivity without necessarily enhancing oversight.

### Background

The member medical schools and teaching hospitals of the AAMC conduct more than half of all extramural research funded by the National Institutes of Health (NIH). Although there are limited data quantifying the regulatory burden on investigators and research institutions to comply with federal regulations, several surveys and reports indicate that compliance and administrative requirements are putting significant strain on the research community.

A 1999 NIH report, *NIH Initiative to Reduce Regulatory Burden* (Mahoney 1999), assessed the impact of five specific areas of regulation (financial conflict of interest, research integrity, human subjects protections, animal care and use, hazardous waste disposal) and recognized that addressing regulatory burden and developing related solutions require robust collaboration among leadership at federal agencies, research institutions, and the research community.

In 2012, the Federal Demonstration Partnership survey found that investigators of federally funded research spent, on average, 42 percent of their research time performing administrative tasks—which included ensuring compliance with federal regulations—instead of conducting research.

That same year, the National Science Board (NSB) convened a Task Force on Administrative Burdens, which engaged federal agencies, the academic community, and other key stakeholders. The final report, *Reducing Investigators' Administrative Workload for Federally Funded Research*, acknowledged that although regulatory requirements are critical, “excess regulations, differing agency requirements, and requirements and delays resulting from institutional concerns about liability ... slow the pace of research without improving scientific or regulatory outcomes” (National Science Board 2014, 19).

Congress has also recognized the urgent need to address regulatory burden. At the request of Congress, the National Academies convened an 18-member Committee on Federal Research Regulations and Reporting Requirements. In September 2015, this committee issued the expedited report, *Optimizing the Nation's Investment in Academic Research: A New Regulatory Framework for the 21st Century Part 1*. The report covers specific regulations and reporting requirements that are important to the research community and that need the immediate action of Congress and the Administration. The report concluded that the continued expansion of federal research regulations is diminishing the effectiveness of the nation's research investment by diverting investigators' time away from research and instead toward administrative and compliance duties. It also noted the insufficient research and data quantifying the burden and cost to investigators and research institutions, citing the AAMC Conflict of Interest Metrics Project as an existing, effective mechanism to quantify regulatory burden.

The Conflict of Interest Metrics Project measured the cost and effectiveness of the NIH 2011 revised regulations on financial conflicts of interest. It found that the total new investment by 71 institutions to fully implement the regulations was nearly \$23 million, with ongoing average annual costs of approximately \$330,000 per institution. At the same time, while institutions reported reviewing a dramatically increased number of significant financial interests, there was not a proportional increase in the number of reported financial conflicts of interest. These findings call into question whether the revised regulation accomplished its intended goals in a manner that appropriately balanced the benefits and burdens of the requirements.

A January 18, 2011, Executive Order (E.O. 13563) emphasized the importance of reducing regulatory burden and costs by requiring a government-wide retrospective review of current regulations. In 2011, the Department of Health and Human Services anticipated that it would save \$4 billion over the course of five years and would remove burdensome reporting requirements imposed on hospitals and health care providers. A July 2016 Government Accountability Office (GAO) report on federal research grant requirements and their administrative workload and costs noted that research funding agencies have tried to reduce administrative burden but recommended that five agencies, including NIH and the National Science Foundation (NSF), identify additional areas where regulatory requirements can be “standardized, postponed, or made more flexible, while maintaining oversight of federal funds.” The GAO report also cited the work of the AAMC Conflict of Interest Metrics Project.

### AAMC Policy Recommendations

- The AAMC strongly supports initiatives to reduce, streamline, and harmonize regulations.
- The AAMC recommends a prospective evidenced-based review of specific regulations before they are finalized, to ensure that the burden imposed by the regulation is justified.
- The AAMC supports the National Academies’ recommendations to implement a framework to assess regulatory burden across federal agencies and to reduce that burden through a decrease in redundant, overlapping, or unnecessary requirements.

### Related Issue

- Research with Human Subjects

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### Web Resources

#### AAMC Conflicts of Interest Metrics Project

[www.aamc.org/initiatives/research/coi/metricsproject](http://www.aamc.org/initiatives/research/coi/metricsproject)

#### AAMC Information on Well-Being in Academic Medicine

[www.aamc.org/initiatives/462280/wellbeingacademicmedicine.html](http://www.aamc.org/initiatives/462280/wellbeingacademicmedicine.html)

*Optimizing the Nation’s Investment in Academic Research: A New Regulatory Framework for the 21st Century*  
[www.nap.edu/catalog/21824/optimizing-the-nations-investment-in-academic-research-a-new-regulatory](http://www.nap.edu/catalog/21824/optimizing-the-nations-investment-in-academic-research-a-new-regulatory)

### References

Mahoney, John. 1999. *NIH Initiative to Reduce Regulatory Burden*. OER Public Archive, National Institutes of Health. <https://archives.nih.gov/asites/grants/06-17-2015/archive/grants/policy/regulatoryburden/index.htm>.

National Science Board. 2014. *Reducing Investigators’ Administrative Workload for Federally Funded Research*. Arlington, VA: National Science Foundation (NSB-14-18). [www.nsf.gov/pubs/2014/nsb1418/nsb1418.pdf](http://www.nsf.gov/pubs/2014/nsb1418/nsb1418.pdf).

## ISSUE SUMMARY

Animal research plays an essential and irreplaceable role in advancing biological knowledge, human health, and veterinary medicine. The AAMC and its member institutions are committed to the welfare of laboratory animals and upholding ethical and legal responsibilities when using animals in research.

### Issue

Animal research has played a key role in virtually every major medical advance of the last century, to the benefit of both human and animal health. It is critical for progress in health and in discovery for scientists to be able to do research in living systems that are genetically similar to humans. Some members of the public have expressed concern about the use of animals in research—at an extreme, attempting to stop the research or cause harm to the scientists conducting the research. However, medical schools and teaching hospitals abide by comprehensive federal, state, and institutional regulations and guidelines to ensure the safety, welfare, and ethical use of laboratory animals.

### Background

The National Institutes of Health (NIH) and the Foundation for Biomedical Research note that advances such as antibiotics, blood transfusions, dialysis, organ transplantation, vaccinations, chemotherapy, bypass surgery, joint replacement, and practically every present-day protocol for the prevention, treatment, cure, or control of disease, pain, and suffering are based on knowledge attained through animal research. The National Association for Biomedical Research additionally notes that every Nobel Prize in Medicine awarded over the past 30 years has been dependent on data gathered from research in animals. Animal models continue to provide invaluable and irreplaceable insights into human systems, and they function as the basis for conducting clinical trials and translating medical discovery into treatments and cures. The essential need for animal testing and research is recognized and supported by the AAMC, NIH, and medical societies and health agencies around the world.

At the federal level, the Animal Welfare Act sets legal standards for the care and use of animals in research. Additionally, the U.S. Public Health Service (PHS) Policy on Humane Care and Use of Laboratory Animals mandates criteria for the proper care and treatment of animals used in biomedical and behavioral research and outlines requirements for institutional programs.

Research institutions are required to establish an Institutional Animal Care and Use Committee (IACUC), which evaluates any proposed experiments. Approval by the IACUC is a prerequisite to receiving federal funding for animal research. The IACUC also monitors the research as it progresses to make sure it continues to meet obligations of the PHS policy.

Medical schools and teaching hospitals whose faculties use animals in research also participate in the voluntary accreditation and assessment program of the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC). Institutions that earn AAALAC accreditation demonstrate their commitment to responsible animal care and use. Institutions understand that the highest quality and most rigorous science can only be achieved through meeting the highest standards in the care of laboratory animals.

### AAMC Policy Recommendations

- The AAMC strongly affirms the essential and irreplaceable role of research involving live animals in advancing biological knowledge, human health, and animal welfare.
- The AAMC affirms the academic medical community's responsibility to ensure that the use of animals in laboratory research is judicious, responsible, and humane and that the care provided to these animals fully meets accreditation standards and regulatory and legislative requirements. It is the association's firm belief that further restrictions on the use of animals in biomedical and behavioral research threaten progress in health care and disease prevention.

## Related Issue

- National Institutes of Health

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## Web Resources

### **NIH's Office of Extramural Research (OER) on Animals in Research**

<https://grants.nih.gov/grants/policy/air>

### **Foundation for Biomedical Research**

<https://fbresearch.org>

### **National Association for Biomedical Research**

<http://www.nabr.org>

### **AAALAC International**

<http://www.aaalac.org>

## ISSUE SUMMARY

As the nation's lead federal agency for research to improve health care quality, the Agency for Healthcare Research and Quality (AHRQ) supports research and disseminates information on evidence-based practices and procedures that improve health care delivery. Through this work, AHRQ serves to strengthen implementation of medical discoveries into practice and to equip patients, providers, and payers with reliable health services data.

### Issue

Implementation and outcomes research provides health care stakeholders the tools and methods to build the evidence base on “what works” in health care and to link this information directly to clinical practice and health systems. This approach allows clinicians and health systems to take full advantage of the research enterprise to develop and deploy cutting edge treatments and models of care. In addition to improving clinical and health systems practice, such work also can help inform patient decision making and can help policymakers better understand the impact of policies on the efficiency and effectiveness of care. Continued and enhanced support for implementation and outcomes research will improve the translation of medical research into care and strengthen the quality and safety of health care in the United States.

### Background

Complementing the medical research supported by the National Institutes of Health (NIH), AHRQ sponsors research on health services, implementation, and outcomes that is designed to improve the quality and safety of health care. As the lead federal agency tasked with improving health care quality, AHRQ's mission is to produce evidence to make health care safer and higher quality and more accessible, equitable, and affordable.

In support of this mission, AHRQ's budget includes a number of research initiatives designed to enhance consumer and clinical decision making, provide improved health care services, and promote efficiency in the organization of public and private systems of health care delivery. AHRQ supports researchers conducting research to understand how to make health care safer and improve quality. Additionally, to foster its important research, AHRQ provides an array of intramural and extramural predoctoral and postdoctoral educational and career development grants and opportunities in health services research.

The nation's medical schools and teaching hospitals conduct and produce much of the research funded by AHRQ and also benefit greatly from the research findings and resources disseminated by AHRQ. As an example, the annual *National Healthcare Quality and Disparities Report* issued by AHRQ is a valuable resource used by institutions to assist with their community health needs assessments and work in advancing health equity. AAMC members also participate in and use the AHRQ Health Care Innovations Exchange, which rapidly disseminates evidence-based tools and strategies for large-scale implementation in the health care system. Research conducted by grantees at AAMC-member institutions has led to significant changes in medical research, practice, and policy, including improving access to care and strengthening quality. For example, this work is enhancing the ability of health systems and health care providers to identify and address clinical care safety issues. Medical education also now integrates instruction on patient safety for students and residents into the curriculum, and AHRQ research on topics such as prevention and chronic care is widely incorporated in continuing medical education (CME) offerings.

In fiscal year (FY) 2016, AHRQ received \$334 million in budget authority, sustaining a \$30 million (8 percent) cut compared with the previous fiscal year. For FY 2017, the AAMC joined the Friends of AHRQ in recommending restoration of AHRQ's budget to \$364 million—a funding level that would allow AHRQ to continue and enhance its initiatives to improve quality and control the cost of the health care system. The AHRQ appropriation is also supplemented by a transfer each year from the Patient-Centered Outcomes Research Trust Fund to build capacity for comparative clinical effectiveness research through training grants and to disseminate findings from comparative clinical effectiveness research.

## AAMC Policy Recommendations

- The AAMC firmly believes in the value of research in health services, implementation, and outcomes as the nation continues to strive to provide high-quality, efficient, and cost-effective health care to all of its citizens. Continued and robust funding for AHRQ is critical to help achieve these goals.
- Spending bills should recognize the complementary nature of research and research agencies rather than imposing problematic prohibitions that impede research to improve patient care.

## Related Issues

- Health Equity
- Other Priority Health and Research Agencies

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## Web Resource

### **Agency for Healthcare Research and Quality**

[www.ahrq.gov](http://www.ahrq.gov)

## ISSUE SUMMARY

Laboratory developed tests (LDTs) are vital elements in providing innovative and tailored treatment options to patients with the assistance of rapidly developing diagnostic tools. Through draft guidance issued in October 2014, the U.S. Food and Drug Administration (FDA) proposed a system of oversight that would begin to regulate LDTs as medical devices. This proposed framework has raised important concerns in the academic medicine community that such regulation has the potential to significantly increase costs, stifle innovation, and ultimately decrease the ability to provide the most effective and appropriate care to patients.

### Issue

In October 2014, the FDA released draft guidance on its proposed oversight of LDTs, which are generally in vitro diagnostic (IVD) tests designed and used by a single laboratory. When LDTs are offered by clinical labs at academic health centers, those labs are subject to regulation under the Clinical Laboratory Improvement Amendments (CLIA) program, which oversees the operations and testing processes. LDTs are not currently regulated by the FDA through the current device regulations, but many would be subject to this regulatory oversight under the proposed guidance. According to the FDA, the purpose of the revised framework is to give the FDA oversight of LDTs “based on risk to patients rather than whether they were made by a conventional manufacturer or a single laboratory.” In this new structure, LDTs designated as higher risk, including companion diagnostics and LDTs used to inform treatment decisions, would be reviewed by the FDA through the existing premarket review process. However, the proposed guidance would exempt very few existing or emerging tests from this new, costly regulatory process, which may unintentionally make it financially and administratively infeasible for academic medical centers to continue developing tests that are tailored for a small number of affected individuals or administered infrequently. Many academic medical centers are concerned that the proposed guidance as initially drafted could suppress innovation in conditions or populations for which there is little incentive for commercial entities to develop tests.

### Background

Immediately after the release of the proposed guidance, academic institutions and other entities raised concerns that the proposed framework would slow down innovation, create a burdensome and expensive process, and potentially jeopardize patient care and advances in personalized medicine. In addition to submitting comments to the FDA on the guidance, several interest groups including physician associations and other health care provider associations, academic entities, and industry each developed alternative proposals to the FDA draft guidance. The alternative proposals address whether the FDA or the Centers for Medicare and Medicaid Services (CMS) should bear primary responsibility for LDT oversight, and they include different approaches for classifying tests based on risk. Those alternative frameworks that propose an expanded role for CMS note that LDTs, while currently not regulated by the FDA, are subject to some level of oversight through CLIA. More “CLIA-centric” proposals suggest that the role of CMS should be expanded by investing additional federal resources in CMS and modernizing CLIA to give greater oversight responsibility and enforcement authority over LDTs. Some have suggested a blended approach, where certain tests, such as those deemed very high risk or those containing proprietary information would be automatically or voluntarily submitted to the FDA for approval, while the vast majority of LDTs would either be regulated through CLIA or not subject to additional regulation. The House Energy and Commerce Subcommittee on Health has also convened hearings on the subject and circulated draft legislation, while the Senate Health, Education, Labor, and Pensions (HELP) Committee held a hearing in September 2016.

The AAMC agrees that LDTs used for diagnostic and treatment decisions should have clinical validity and accuracy. However, we share our members' concerns that the FDA's regulation of LDTs as proposed would interfere with delivering innovative, cutting-edge medical care, negatively impact patients, or mire the development of critical new tests in a costly and laborious process. LDTs are often innovative or low-volume tests whose speed of adoption has outpaced the ability of commercial IVD manufacturers to plan and submit formal clinical trials that would be required for the FDA approval for marketing.

As the AAMC wrote in its comment letter to the FDA, academic medical centers and teaching hospitals that are performing LDTs every day are "on the front line of patient care and are best able to define the impact on their own institutions and their ability to treat patients with important information gleaned from clinically validated, well-proven, and carefully tailored diagnostic tests. In light of the president's initiative on precision medicine, the FDA should be working in concert with academic medicine to encourage innovation in patient care, not stifle it."

### AAMC Policy Recommendations

- Any potential revised regulatory framework must avoid an overly burdensome system that would greatly slow innovation critical to keeping our health care system vital, providing care to patients, and responding quickly to emerging public health risks.
- The breadth of any potential regulation of currently used tests that have demonstrated validity should be limited. Given the cost of guiding even a single test through the FDA premarket approval process, the AAMC is concerned that institutional investment in each currently used LDT would be economically untenable, not only limiting patient access to new innovative and targeted diagnostic tests but potentially making diagnostic tests that are available today unavailable in the future.
- Before finalizing any potential framework, policymakers should determine the current frequency and types of modifications to existing tests to inform which modifications would require a new approval process.
- Any potential regulation of LDTs should include a wide range of situations under which enforcement jurisdiction or grandfathering is applied to facilitate the continued use of current well-known and well-developed tests without undue burden on the system as a whole. A system that recognizes the proven success and validity of certain tests or categories of LDTs is essential to ensure that the nation's resources are targeted to reviewing the subsection of diagnostic tests that present the most potential risk to patients.

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### Web Resources

#### AAMC Comment Letter to FDA on Regulation of LDTs

[www.aamc.org/download/423626/data/aamccommentsonfdaproposedguidanceonldts.pdf](http://www.aamc.org/download/423626/data/aamccommentsonfdaproposedguidanceonldts.pdf)

#### FDA Information on LDTs

[www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm407296.htm](http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/InVitroDiagnostics/ucm407296.htm)

## ISSUE SUMMARY

Medical discovery and advancement requires effective research across a continuum from basic science to clinical, health services, and health systems research. Accordingly, it is vital to support research, health agencies, and initiatives across the spectrum.

### Issue

In addition to agencies described elsewhere in this collection of policy priorities, several federal agencies, both within and outside the Department of Health and Human Services (HHS), award grants to medical schools and teaching hospitals to advance the continuum of research and discovery. These include the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Science Foundation (NSF), the Department of Veterans Affairs (VA), and the Patient-Centered Outcomes Research Institute (PCORI).

### Background

#### CDC

As the nation's lead prevention agency, the CDC is responsible for promoting health and quality of life through efforts to prevent and control disease, injury, and disability. The CDC works with states, local public health agencies, and partners across the nation to monitor health, detect and investigate disease outbreaks, conduct research to enhance prevention, develop and implement sound health policies, foster healthy environments, and provide needed leadership and training in public health. The CDC is an important part of the public health continuum, and the AAMC-member institutions play a significant role in carrying out the CDC's extramural programs, activities, and research.

Since October 2000, the AAMC has maintained a cooperative agreement with the CDC to enhance collaborations between the academic medical and public health practice communities. Priority areas of interest shared by the CDC and the AAMC at that time were promoting the teaching of prevention and public health in academic medical centers, promoting the training of public health and prevention researchers, increasing the number of underrepresented minority students in medical schools, and mitigating health disparities. The cooperative agreement was renewed in August 2012 for five years to support enhanced teaching of population health concepts and to provide practical, hands-on experience at the community level for public health, medical, and nursing students.

#### HRSA

HRSA serves as the primary federal agency dedicated to improving access to health care services, especially for the uninsured, the underserved, and medically vulnerable populations. Tasked with strengthening the nation's health care safety net, HRSA grants augment other federal programs by supporting direct health care access for the uninsured, individuals with HIV/AIDS, pregnant women, mothers, and children; the training of health professionals; and improved systems of care in rural communities. HRSA also has programs that support various research initiatives, such as grants to conduct primary care research through Title VII primary care training programs and the National Research Service Award for Institutional Research Training program. In addition to the Title VII health professions training programs and the National Health Service Corps, HRSA also administers the Children's Hospitals Graduate Medical Education program, which provides funds to support the training of residents in children's hospitals.

#### NSF

The NSF is an independent federal agency supporting basic science and engineering across all disciplines; it is the second largest sponsor of research at colleges and universities after the National Institutes of Health. The NSF funds approximately 11,000 research, education, and training projects through grants, contracts, and cooperative agreements at more than 2,000 colleges, universities, and other research and education institutions. The NSF also plays an important role in supporting efforts to improve science, math, and engineering education at the K-12 level, as well as at colleges and universities. The AAMC is a member of the Coalition for National Science Funding (CNSF), which advocates for robust funding for the NSF science, engineering, and education basic research programs.

#### VA Research

Funding for VA research must be steady and sustainable to meet current commitments while allowing for innovative scientific growth to address critical emerging needs, including conditions prevalent among new veterans as well as the increasing health

needs of aging veterans. Under the president's Precision Medicine Initiative, the AAMC supports the Million Veteran Program—an initiative that seeks to collect the genetic samples and health information from 1 million veterans to drive the future of research and medicine—without reducing funding for other designated research areas. The AAMC collaborates with the Friends of VA Medical Care and Health Research (FOVA) coalition and the Independent Budget Veterans Service Organizations to develop funding recommendations for VA research.

### PCORI

PCORI is an independent, nonprofit organization that was authorized by Congress in 2010. Since its inception, the institute has made substantial progress in developing a national infrastructure for the conduct of comparative clinical effectiveness research (CER) and other efforts to strengthen decision making by patients and providers. CER and patient-centered outcomes research are a central component of sustainable health care reform because they improve the quality and effectiveness of care. A 21-member Board of Governors appointed by the Government Accountability Office and representing patients; physicians, hospitals, and other providers; private payers; pharmaceutical and device manufacturers; quality improvement or independent health service researchers; and federal agencies oversees PCORI's work, and a 17-member Methodology Committee defines methodological standards for research.

PCORI is funded through the Patient-Centered Outcomes Research Trust Fund (PCORTF), which receives income from a combination of mandatory appropriations (\$150 million in each of the fiscal years [FYs] 2013–2019), transfers from the Medicare and Medicaid trust funds, and a fee assessed on private insurance and self-insured health plans (as of April 2016, \$2.17 per covered person). The trust fund is scheduled for reauthorization in 2019. As institutions that both generate and use patient-centered outcomes research, AAMC-member medical schools and teaching hospitals are among the most frequent PCORI grantees. In FY 2016, 76.6 percent of PCORI award funding supported medical schools and teaching hospitals.

### AAMC Policy Recommendations

- The interrelated and interdisciplinary nature of research, including basic, public health, clinical, health services, and comparative effectiveness, requires robust and reliable support for complementary research agencies. And to fully

maximize the potential of medical research, it is critical to augment support for these agencies with investments in the federal programs and agencies that help ensure that the findings can reach the broadest spectrum of the patient population.

- The AAMC recommends increased funding for VA Medical and Prosthetic Research in FY 2018 for biomedical inflation, critical emerging research needs, and the Million Veteran Program.
- As a member of the Friends of HRSA, the AAMC supports robust funding for HRSA programs and research to improve access to health care services and the nation's health care safety net.
- The AAMC supports adequate and continued funding for the CDC to improve emergency preparedness and prevention programs, support local and state public health programs, and coordinate the nation's defense against emerging and known threats.
- The AAMC supports continued funding of PCORI to continue its work in strengthening the decision-making process for patients and providers.

### Related Issues

- National Institutes of Health
- Caring for Our Nation's Veterans

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### Web Resources

#### Friends of VA Medical Care and Health Research

[www.friendsofva.org](http://www.friendsofva.org)

#### Coalition for National Science Funding

[www.cnsfweb.org](http://www.cnsfweb.org)

#### Friends of the Health Resources and Services Administration

[www.friendsofhrsa.org](http://www.friendsofhrsa.org)

#### Centers for Disease Control and Prevention Coalition

[www.cdccoalition.org](http://www.cdccoalition.org)

## ISSUE SUMMARY

Fifty years ago, Medicare made a commitment not only to provide health care for the elderly but also to help train a sufficient number of physicians to meet the needs of the country. Medicare must continue to provide sufficient and stable funding for direct graduate medical education (DGME) and the indirect medical education (IME) adjustment. This funding supports teaching hospitals as they train new physicians to meet the increasing requirements of an aging population and helps pay for the additional patient care costs incurred by teaching hospitals for the services they provide and the patient populations they treat. In addition, although the Affordable Care Act (ACA) reduced the number of uninsured in this country, safety net hospitals continue to need Medicare Disproportionate Share Hospital (DSH) funding to provide uncompensated care for the large numbers of patients who are still uninsured and underinsured. Finally, teaching hospital outpatient departments (HOPDs) are critical access points for many Medicare patients. These sites cannot sustain further payment cuts.

### Issue

Major teaching hospitals and physician faculty practices serve a disproportionately large volume of Medicare beneficiaries. Teaching hospitals, many of which are safety net providers, care for vulnerable populations who often cannot seek treatment elsewhere. Simultaneously, teaching hospitals are tasked with training future physicians, as well as other health care providers, to meet the nation's health care needs. Projections show the country will need between 61,700 to 94,700 new physicians in the next 10 years. In 1997, as part of the Balanced Budget Act, a hospital-specific limit ("cap") was placed on the number of residents that a teaching hospital can count for purposes of receiving DGME and IME payments. However, because of their educational mission and the looming physician shortage, about half of the teaching hospitals are training residents in excess of their caps, with no additional IME or DGME payments. With shrinking clinical margins, if these payments are not maintained it will be a challenge for teaching hospitals to continue to support their teaching and clinical care missions.

It is imperative that Congress continue to ensure that Medicare supports teaching hospitals through the DGME payment, the IME payment adjustment, and Medicare DSH payments. Cuts to funding would directly threaten teaching hospitals' ability to provide quality care to Medicare beneficiaries and other patients. Spending must be stable and predictable to allow teaching hospitals to continue to train the nation's future physicians and carry out core missions to provide quality patient care, conduct research, and teach the next generation of this nation's physicians.

While representing just 5 percent of the nation's hospitals, AAMC-member teaching hospitals provide 35 percent of total hospital charity care in this country. Congress recognized the importance of teaching hospitals in providing access to low-income patients and established the Medicare DSH payment to help alleviate operating costs associated with treating these patients who often are sicker or have more complex conditions than other patients. Medicare DSH payments have decreased under provisions of the ACA based on the expectation that the percentage of uninsured individuals would decline. Yet, Medicare DSH payments remain a critical resource for major teaching hospitals that continue to provide a disproportionate amount of uncompensated care to low-income patients.

To care for these challenging and underserved patient populations, teaching hospitals often place remote HOPDs in the community. Medicare historically has recognized that HOPDs are essential care settings in the health care landscape and that they differ from physician offices and ambulatory surgical centers in key ways that warrant different payment methods and rates. This payment differential appropriately accounts for the differences in the patients treated, services provided, and regulatory burden at HOPDs. For example:

- HOPDs are frequently the sole sources of care for low-income and otherwise underserved populations of Medicare beneficiaries, accepting those who otherwise face difficulty being seen in physician offices.
- HOPDs need to meet the myriad regulatory requirements of their association with a hospital, including compliance with hospital conditions of participation and providing standby care not provided in a physician's office.

- HOPDs are settings for comprehensive and coordinated care for patients with chronic or complex conditions. Many centers of excellence are based in hospital settings and provide outstanding team-based, patient-centered care.
- HOPDs provide wraparound services, such as translators and other social services.

## Background

Today, there are more than 55 million Medicare beneficiaries, more than three-quarters of whom are over the age of 65. Close to half of all beneficiaries live with four or more chronic conditions, and one-third may not be able to function independently because of one or more limitations in activities of daily living, such as eating or bathing. In the coming years, the ranks of the Medicare population will swell as increasing numbers of the “baby boom” generation reach age 65. At the same time, however, the United States is facing a looming physician shortage. Teaching hospitals account for 20 percent of all Medicare inpatient days and provide clinical training for nearly three-quarters of all medical residents.

The distinctive capabilities and responsibilities of teaching hospitals do not come without a price. Teaching hospitals incur significant costs associated with training new physicians and other health care professionals. They also have costs associated with using newly developed devices and technologies, maintaining standby services, treating patients with complex conditions, providing unfunded and underfunded health services, being sites for clinical research, and serving as safety net providers. These activities impose substantial financial burdens on teaching hospitals. Congress established several payment adjustments to help teaching hospitals with their operating costs. Teaching hospitals continue to rely on these payments to train new physicians and provide high-quality care to low-income patients. These unique services benefit not only Medicare beneficiaries but all patients in the community.

Medicare also provides two additional distinct payments to teaching hospitals. The Medicare DGME payment is a vital source of funding for teaching hospitals that educate the physician workforce of the future. However, Medicare only pays its “share” of these costs, based on a teaching hospital’s ratio of Medicare inpatient days to total inpatient days.

Despite its label, the IME adjustment is a patient care add-on payment intended to help pay for the higher costs incurred by teaching hospitals due to a number of factors, such as treating a more complex patient population, having full service facilities for care, supporting the educational mission, and providing services that benefit the community, such as burn units, that often are unavailable elsewhere. Like DGME payments, because IME payments are an add-on to each Medicare discharge, Medicare is only paying its share of these higher costs.

The Bipartisan Budget Act of 2015 included a new hospital payment policy (Sec. 603) that reduced payment rates at newly established off-campus HOPDs to equal those of physician offices or ambulatory surgical centers (ASC). As of November 2, 2015, any site that enters into a Medicare provider agreement but is not located on the hospital main campus and is located more than 250 yards away from the main campus must be paid according to the ASC prospective payment system or the Medicare Physician Fee Schedule (PFS). This so-called “site neutral” policy disregards the critical and real differences between HOPDs and physician offices, including the increased costs of providing care in an outpatient setting, the complex case mix of patients seen there, and their essential role in medical education. While existing HOPDs were grandfathered and not subject to the new payment policy, sites that were under development or “mid-build” were not addressed. The AAMC strongly supports policies that would exempt “under development” off-campus HOPDs, as well as grandfathered HOPDs that relocate, renovate, or add services.

## AAMC Policy Recommendations

To sustain our nation's teaching hospitals and the irreplaceable services they provide, the AAMC urges the following steps be taken:

- Lift the Medicare resident caps.
- Maintain the DGME payment and IME adjustment at their current levels.
- Adequately increase Medicare DSH payments to ensure appropriate reimbursement for teaching hospitals as they continue to see an increase in the disproportionate number of uninsured and underinsured patients they care for.
- Refrain from additional reimbursement reductions in Medicare HOPD payment policy.
- Implement policies that provide flexibility for existing HOPDs and relief for hospitals with HOPDs that were mid-build when the Bipartisan Budget Act of 2015 was passed.

## Related Issues

- Medicare Physician Payment and Quality
- Medicaid
- Physician Workforce Issues

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## Web Resource

### AAMC Information on Teaching Hospitals

[www.aamc.org/newsroom/keyissues/teaching\\_hospitals](http://www.aamc.org/newsroom/keyissues/teaching_hospitals)

## ISSUE SUMMARY

Hospital and physician quality measures and programs, where appropriate, should be adjusted to account for the sociodemographic status (SDS) of patients. Without this risk adjustment, hospitals and physicians who treat the nation's sickest and most vulnerable patients continue to be inappropriately penalized by quality performance programs.

### Issue

Over the past five years, Medicare has moved to link provider payments to quality and efficiency outcomes. In general, the AAMC supports this transition. However, numerous outcome measures (i.e., readmissions, mortality, episode payments, etc.) are greatly influenced by conditions that occur outside of the provider's control. For example, a patient who is discharged from a hospital and does not have access to a pharmacy or lacks family to ensure that an appropriate care plan is followed is far more likely to return to the hospital than a patient who has these supports. The current provider quality programs and measures are not adjusted to account for this variation in patient populations and, as a result, unfairly penalize hospitals and physician groups that care for the most disadvantaged and vulnerable communities.

### Background

Characteristics of low-SDS patients include low income, minimal education, English as a second language, inability to access pharmacies, lack of a familial or community support infrastructure, and lack of access to primary care physicians, among others. Low-SDS patients tend to be sicker and, for a number of reasons, may not have access to preventive care. There is no single measure of SDS (also referred to as socioeconomic status [SES]), and there is no consensus on how best to adjust quality measures or programs to account for this patient population. There is, however, overwhelming evidence that Medicare's quality programs (such as the Hospital Readmissions Reduction Program [HRRP]) disproportionately penalize those institutions and physicians who care for low-SDS patients.

There have been and continue to be many federal initiatives to examine the inclusion of SDS into provider quality programs, including the following:

- In July 2016, the National Academies of Sciences, Engineering, and Medicine released the third report from its Committee on Accounting for SES in Medicare Payment Programs. The committee describes four approaches the Centers for Medicare and Medicaid Studies (CMS) could implement to account for SES factors, including changes to data reporting and payment adjustments.
- In 2015, the Medicare Payment Advisory Commission (MedPAC) reiterated its 2013 recommendations to modify the HRRP to address SDS factors, specifically by stratifying hospitals by the proportion of low-income Medicare beneficiaries they treat. MedPAC reports that such an approach could be implemented quickly, while ensuring "hospitals with the highest shares of low-income patients will still have an incentive to continue improving their readmission rates."
- In 2014, the National Quality Forum (NQF) convened a technical expert panel to examine risk adjustment for SDS and other social determinants of health. The panel made 10 recommendations for incorporating SDS risk adjustment into quality measurement and reporting, including that all measures used in accountability or payment programs should be risk adjusted for clinical factors and sociodemographic factors. The NQF is currently conducting a trial period to put these recommendations into action.
- CMS has recognized the role of SDS factors in the Medicare Advantage program, particularly how plan performance on quality metrics is affected by the proportion of low-income Medicare beneficiaries they enroll. In 2016, CMS finalized a policy to adjust the Medicare Advantage Star Ratings metrics for plans that serve a disproportionate number of low-income beneficiaries.

The AAMC strongly supports policies that would adjust hospital performance in the HRRP and other quality programs by SDS.

### AAMC Policy Recommendations

- Pass legislation to ensure that the HRRP, along with other quality programs as appropriate, is adjusted for SDS.
- Implement regulations that incorporate SDS adjustments into the existing provider quality programs, as appropriate.
- With regard to the CMS Hospital Compare Star Ratings: Stratify the overall star ratings by the number of measures reported; remove flawed measures from the ratings, most notably, the PSI-90 composite measure; and adjust the star ratings for SDS, as has been implemented in the Medicare Advantage star rating system.

### Related Issues

- Health Care Quality
- Medicare Physician Payment and Quality

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### Web Resources

**AAMC Government Affairs and Advocacy**  
[www.aamc.org/advocacy](http://www.aamc.org/advocacy)

**AAMC Hospital Payment and Quality**  
[www.aamc.org/hospitalpaymentandquality](http://www.aamc.org/hospitalpaymentandquality)

*Journal of the American Medical Association (JAMA)*  
**Report: Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program**  
<http://jama.jamanetwork.com/article.aspx?articleid=1558273#ref-jld120031-6>

## ISSUE SUMMARY

Physician payment policies are changing, moving toward paying providers based on the quality rather than the quantity of care. As Medicare implements value-based payment systems and new delivery models, it is important to recognize and, where necessary, address the unique challenges posed by these new programs for physicians who practice at academic medical centers (AMCs). Clinical physicians at AMCs make up large multispecialty practices that treat the most complex and vulnerable patient populations, many of which require highly specialized care.

### Issue

In 2015, Congress made significant changes to physician payment policy by enacting the Medicare Access and CHIP Reauthorization Act (MACRA), which repeals the sustainable growth rate (SGR) formula, establishes predictable payment increases, and provides incentives for physicians to be paid based on the quality of services they provide and participation in alternative payment models (APMs). This law marks a fundamental shift in how fee levels for physicians are set: from a basis of overall growth in Medicare spending to one of indicators of cost and quality.

As the Centers for Medicare and Medicaid Services (CMS) implement the significant changes to physician payment mandated by MACRA, predominantly the Quality Payment Program (QPP), it is essential to address the unique needs of large, multispecialty group practices, such as those typically found in academic medical centers. Clinicians in AMCs treat the most vulnerable patients: those who are poor and sick and have complex medical needs. Adequate reimbursement and appropriate measures of cost and quality are vital to sustain the education and training and the safety net and community service missions of academic clinical physicians. On average, Medicare accounts for approximately one-quarter of the revenue of a teaching physician.

### Background

MACRA, which permanently repealed the flawed SGR formula, will provide positive annual updates of 0.5 percent through 2019 and 0 percent updates through 2025.

MACRA included other provisions affecting Medicare's payments for clinician services. Specifically, MACRA created two payment pathways for physicians to receive payment adjustments under the QPP: the Merit-Based Incentive Payment System (MIPS)

and APMs. Under MIPS, performance and "merit" will be judged based on four domains: quality of care, resource use, meaningful use of electronic health records, and participation in clinical practice improvement activities.

Due in part to their size and structure, AMC physician practices face unique challenges when deciding how to approach the MACRA QPPs. For myriad reasons, these groups of faculty physicians, who provide care as large multispecialty practices, are frequently organized under a single tax identification number (TIN) that includes a large number of physicians and eligible clinicians. Recent AAMC data show these plans range in size from a low of 128 individual national provider identifiers (NPIs) to a high of 4,319, with an average of 983. Some have more than 70 adult and pediatric specialties with numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery.

Teaching physicians care for the sickest, most complex Medicare patients and provide primary care as well as highly specialized services that may not be available elsewhere in the community. Moreover, academic physicians are often a resource for other health care providers in communities and across regions, providing consultations and care for Medicare patients who need their specialized expertise, while at the same time teaching the next generation of physicians.

As the new quality programs are implemented, there is a need for meaningful measures that add value, are tested in the field and accepted by physicians, are useful to consumers, and promote alignment across programs.

## AAMC Policy Recommendations

As Medicare changes the payment system for physicians it is critical to have fair physician payment adjustments and meaningful measures of performance. Key recommendations regarding the QPP under MACRA include the following:

- Simplify the MIPS program to decrease administrative burden and enable successful participation.
- Accommodate the unique needs of physicians in large multispecialty practices. These physicians treat the most complex and vulnerable patients, many of whom require complex care from numerous specialties.
- Risk adjust quality measures and use of resources for clinical complexity and sociodemographic status to avoid disadvantaging physicians, such as those in AMCs, who care for the most complex and vulnerable populations.
- Establish flexible requirements around the classification of qualified APM participants to allow for maximum participation.

## Related Issues

- Physician Workforce Issues
- Alternative Payment Models

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## Web Resource

### AAMC Information on Physician Payment and Quality

<https://www.aamc.org/initiatives/patientcare>

## ISSUE SUMMARY

Medicaid, administered by states and jointly funded by states and the federal government, is the largest health insurance program in the United States, providing coverage to more than one in five Americans—more than 65 million beneficiaries. The Children's Health Insurance Program (CHIP) covers another 8.3 million children at any point in the year. Teaching hospitals are core institutions in the health care safety net and serve a disproportionate number of Medicaid and CHIP beneficiaries. This means teaching hospitals support efforts to ensure that Medicaid patients have access to care, and they are all too aware when Medicaid policies threaten that access. State Medicaid programs vary considerably; the federal government can do more to ensure that this variation is used to innovate and improve health outcomes—not to short-change providers and beneficiaries through payment rates that are too low and networks that exclude key providers.

### Issue

Medicaid is a cornerstone of the health care landscape, affecting nearly every hospital in every community nationwide. Unfortunately, this vital program has been perennially and increasingly underfunded due to state budget crises and inadequate federal oversight and investment. Overall, states are reducing their contributions to Medicaid and relying increasingly on health care providers themselves to finance the program. The federal government has scheduled a \$9 billion cut, beginning in fiscal year (FY) 2018, in Disproportionate Share Hospital (DSH) payments to hospitals serving the most Medicaid beneficiaries. Unless Congress acts, funding for CHIP will expire on September 30, 2017. The financial instability of the program hinders thoughtful long-term policymaking at both the federal and state levels, leaves provider payments notoriously insufficient, and jeopardizes Medicaid beneficiaries' access to high-quality care.

Academic medical centers serve a disproportionate number of Medicaid and CHIP beneficiaries and have pioneered ways to meet both the medical and psychosocial needs of underserved communities despite low Medicaid reimbursements. As the Medicaid program continues to grow, the federal government must champion new investments in Medicaid access, sustainability, and quality.

### Background

Major teaching hospitals, medical schools, and their clinical physician faculties are fundamental components of the nation's health care safety net. While representing just 5 percent of the nation's hospitals, major teaching hospitals account for 25 percent of all Medicaid hospital care and provide 35 percent of total hospital charity care in this country. Additionally, major teaching

hospitals have large ambulatory clinics that often become surrogate medical homes for individuals living in neighborhoods without access to other sources of care.

The Affordable Care Act (ACA) and the subsequent U.S. Supreme Court ruling provided states the option to expand Medicaid eligibility to nearly all low-income adults with incomes at or below 138 percent of the federal poverty level with full federal financing for the first three years, gradually decreasing to 90 percent federal funding. As of October 2016, 32 states (including the District of Columbia) have expanded their Medicaid programs to include this new population, providing Medicaid coverage to more than 15 million previously uninsured Americans.

Coverage expansion alone, however, is insufficient to create a sustainable, high-quality Medicaid program. Medicaid reimbursements to hospitals and physicians are unsustainably low. The Government Accountability Office (GAO) has found them to be 65 percent lower than median commercial insurance payments in various markets, and many studies have found providers of all types and specialties to be less likely to accept new Medicaid patients than patients with other forms of insurance. Academic medical centers proudly take on the mission of serving Medicaid beneficiaries, but cross-subsidizing from other missions to make up for Medicaid shortfalls is unsustainable as a long-term strategy and puts training, research, and other priorities at risk.

The Medicaid statute acknowledges the additional burden facing hospitals caring for large numbers of Medicaid beneficiaries and uninsured patients. Supplemental payments—Medicaid DSH payments—support these hospitals. Federal spending on Medicaid DSH is capped, and within that cap, each state

has a specific “allotment” or limit up to which it can draw down matching funds. The combination of state and federal Medicaid DSH funding was approximately \$18 billion in FY 2016.

Anticipating a nationwide expansion in Medicaid coverage and a reduction in uninsured patients, the ACA included more than \$9 billion in cuts to the federal contributions to DSH, to be phased in beginning in FY 2014. These cuts were subsequently delayed by Congress and are currently scheduled to begin in FY 2018. Cuts of this magnitude would devastate the health care safety net, especially in states that have not yet expanded Medicaid, but also in teaching hospitals around the country because 24 million Americans remain uninsured, and Medicaid reimbursement to providers is unsustainably low without supplemental payments like DSH.

In addition to their safety net missions, teaching hospitals also rely on funding from Medicaid to further their academic, training, and research missions. Though not mandatory, 42 states currently contribute to Medicaid graduate medical education (GME) to help offset the higher costs associated with training residents in teaching hospitals. These supplemental payments allow more physicians to be trained in safety net institutions, which improves cultural competence, coordination between health care and community organizations, and access for Medicaid beneficiaries. The federal government collects scant data on Medicaid GME programs, but the AAMC conducts regular surveys and makes its findings public. Issues on the horizon include the maintenance of these funding streams, particularly as states increasingly move their Medicaid programs toward managed care.

Created in 1997, CHIP provides coverage to uninsured children who are not eligible for Medicaid but cannot afford private coverage. Like Medicaid, CHIP is jointly funded by states and the federal government, and states retain considerable flexibility to set eligibility and benefits. Unlike Medicaid, however, CHIP is not a permanent program and requires periodic reauthorization and appropriations to continue. The current authorization and funding expire on September 30, 2017.

Though the ACA Marketplaces now allow families ineligible for Medicaid to purchase affordable insurance, letting CHIP lapse would have devastating, unintended consequences. A feature of the ACA, known as the “family glitch,” misaligns the affordability test for low-income working parents and could leave more than 2 million children uninsured, according to the Center on Budget

and Policy Priorities. Further, CHIP provides a more generous benefit package for children than many plans offered through the Marketplaces, making it an important safety net for the most vulnerable low-income children.

### AAMC Policy Recommendations

- Congress should maintain the federal government’s commitment to match state spending on medically necessary care for Medicaid beneficiaries, without limits, caps, or block grants.
- The federal government should ensure that Medicaid beneficiaries have meaningful access to high-quality care by enforcing network adequacy requirements and mandating sufficient payments to providers.
- Congress should delay scheduled cuts to Medicaid DSH.
- The federal government should encourage states to continue to provide Medicaid GME funding for the training of future physicians, particularly as the nation faces a physician shortage.
- Congress should permanently reauthorize CHIP funding and make such funding permanent rather than subjecting it to the regular appropriations process.

### Related Issues

- Medicare Mission Payments to Teaching Hospitals
- Medicare Physician Payment and Quality

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### Web Resource

**AAMC Information on Medicaid**  
[www.aamc.org/advocacy/medicaid](http://www.aamc.org/advocacy/medicaid)

## ISSUE SUMMARY

In collaboration with the Department of Veterans Affairs (VA), the nation's medical schools and teaching hospitals have an unwavering commitment to veterans who have so bravely served this country. The AAMC believes VA graduate medical education, joint ventures, sole-source contracting, and the proposed Core Network of the Veterans Choice Program help ensure access for our nation's veterans to the highest-quality care by preserving academic affiliates as a direct extension of VA care and a preferred provider.

### Issue

There is a pressing need for physicians to care for our nation's veterans now and in the future. VA physician shortages are symptomatic of a broader trend, the proverbial "canary in the coal mine." The AAMC projects a nationwide shortage of between 61,700 and 94,700 physicians by 2025. Though these shortfalls will affect all Americans, the most vulnerable populations, like veterans in underserved areas, will be the first to feel the impact.

Academic partnerships facilitate the joint recruitment of faculty to provide care at both VA and academic medical facilities. VA graduate medical education (GME) programs also educate new physicians on cultural competencies for treating veteran patients (inside and outside the VA) and help recruit physicians to the VA after they complete their residency training. According to results from the VA's Learners' Perception Survey, residents that rotate through the VA are nearly twice as likely to consider employment at VA institutions.

VA sole-source contracting allows academic affiliates to plan, staff, and sustain infrastructure for certain complex clinical care services for veterans that are scarcely available elsewhere. VA Directive 1663 states, "Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the service contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete."

However, by VA's own estimation, once the decision to contract out care has been made, VA sole-source contracting with trusted academic affiliates takes longer than the formal competitive solicitation process. In 2016, the Government Accountability Office (GAO) found it takes multiple years on average to develop and award high-value, long-term sole-source affiliate contracts, partially as a result of a process that is not designed for clinical service agreements.

### Background

In 2016, the VA and academic medicine celebrated their 70th anniversary. This relationship dates back to the end of World War II when the VA faced a severe shortage of physicians as nearly 16 million men and women returned from overseas, many with injuries and illnesses that would require health care for the rest of their lives. At the same time, many physicians were returning from the war without having completed residency training.

The solution was VA-academic affiliations established under VA Policy Memorandum No. 2, making the VA an integral part of residency training for the nation's physicians. In return, the VA improved access and quality of care for our nation's veterans through U.S. teaching hospitals that provide around-the-clock, on-site, fully staffed standby services for critically ill or injured patients, including trauma centers, burn care units, comprehensive stroke centers, and surgical transplant services.

What started as a simple idea in a time of great need has developed into an unprecedented private-public partnership. Today, the VA has more than 500 academic affiliations, and 127 VA facilities have affiliation agreements for physician training with 135 of the 147 U.S. medical schools.

The VA is an irreplaceable component of the U.S. medical education system. Combined, VA medical centers are the largest trainer of physicians and fund approximately 10 percent of GME in the United States. Every year, the VA trains more than 40,000 medical residents within its walls and is currently working to add 1,500 GME positions over five years. The vast majority of VA residency programs are sponsored by an affiliate medical school or teaching hospital. Without these affiliations, many VA programs would be unable to meet the requirements set by the Accreditation Council for Graduate Medical Education (ACGME). A provider referral preference for academic affiliates under patient care service contracts helps ensure an adequate and diverse patient load necessary for GME program accreditation.

### AAMC Policy Recommendations

- To help recruit physicians to the VA, the AAMC recommends increasing VA graduate medical education, including funding for non-VA facilities that support residents rotating through the VA.
- The AAMC supports expanding VA's authority to establish joint ventures with academic affiliates for shared health care resources, including medical personnel, services, equipment, infrastructure, and research capacity.
- The AAMC encourages VA sole-source contracting reform that improves relationships with academic affiliates by standardizing affiliate contracts with templates, lifting the threshold for VA Office of the Inspector General (OIG) contract review, and recognizing academic appointments as added value rather than conflicts of interest.
- The AAMC supports the VA's plan to consolidate community care, which includes academic affiliates in the proposed Core Network of the Veterans Choice Program.

### Related Issues

- Other Priority Health and Research Agencies
- Medicare Mission Payments to Teaching Hospitals

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### Web Resources

**AAMC Information on Helping Our Nation's Veterans**  
<https://www.aamc.org/initiatives/vahealthcare>

**AAMC Letter to Senate and House Veterans Affairs Committees on Importance of VA's Academic Affiliations**  
<https://www.aamc.org/download/457436/data/aamcsendsletterhighlightingtheimportanceoftheva-academicaffilia.pdf>

## ISSUE SUMMARY

As currently constructed, Medicare's hospital quality performance programs disproportionately, and inappropriately, disadvantage the nation's teaching hospitals. The AAMC strongly supports a transparent and beneficial quality program. However, Medicare must update its measures and programs to ensure that all hospitals are assessed on a level playing field. The issues outlined below only pertain to quality measures and programs required by Medicare. The AAMC's Sociodemographic Status policy statement has a more in-depth summary of concerns related to the lack of a sociodemographic status adjustment in hospital and physician quality programs.

### Issue

Over the last five years, Medicare has implemented hospital quality performance and penalty programs to incentivize improved patient care. Unfortunately, these programs disproportionately disadvantage teaching hospitals due to the lack of appropriate risk adjustment to account for the complexity of patients treated and for activities beyond the hospital's control. Improving the quality of patient care and advancing clinical improvements are an integral part of AAMC members' missions of patient care, research, and medical education. Teaching hospitals and teaching physicians practice care that emphasizes quality improvement while serving the most complex and chronically ill patients in the nation. Medicare must recognize this unique role of these providers in its quality programs to ensure these institutions can continue to fulfill this important mission.

### Background

Beginning in 2012, Medicare introduced three new quality programs that tie a hospital's payment to performance on a series of metrics. These hospital quality programs are as follows:

- Hospital Value-Based Purchasing (VBP) Program, a pay-for-performance program that rewards or penalizes hospitals up to 2 percent of their base payment based on performance for a variety of measures
- Hospital Readmissions Reduction Program (HRRP), a program that penalizes hospitals up to 3 percent for excess readmissions for selected conditions
- Hospital-Acquired Condition Reduction Program (HACRP), a program that assesses 25 percent of hospitals with a 1 percent penalty for performance that is lower than other hospitals on certain patient safety measures

While the AAMC supports the concepts of all three hospital quality programs, there are serious flaws in each that must be addressed. A significant number of the metrics used, such as those focused on reducing readmissions, assess care that occurs outside of the hospital's direct control and do not consider whether a patient has access to appropriate follow-up care or general community support. Patients who are sicker, do not have family to care for them, or have limited access to medicine or healthy food are more likely to return to a hospital for care, inappropriately resulting in "excess readmissions" under Medicare's policies. The metrics also need more precision to better reflect the complexity of patients treated. The nation's teaching hospitals disproportionately care for a complex and vulnerable patient population and are penalized by the lack of appropriate risk adjustment when performance measure scores are determined.

In addition, Medicare's quality programs treat all types of hospitals with the same broad criteria. There are no adjustments for the size or location of the hospital or for the sociodemographic status of the patients treated. A major teaching institution with 500 beds serving a large number of Medicare patients located in the middle of a city is currently directly compared with a 20-bed hospital in an affluent suburb. The complexity of patients and treatments, along with the number of quality measures reported, are vastly different between these two types of hospitals. This complexity is frequently not accounted for in the quality metrics; as a result, many teaching institutions are disadvantaged.

## AAMC Policy Recommendations

The federal government should continue to encourage policies that help providers advance quality and patient safety and improve and strengthen the hospital quality performance programs. Key recommendations include the following:

- The measures used in quality programs should accurately recognize differences among hospitals and the patients they serve. Appropriate risk-adjustment methodologies should be used to account for these differences in patient populations.
- The measures used to assess performance should be evidence based, tested, feasible, and statistically valid.
- For purposes of quality measurement, public reporting, and payment, similar categories of hospitals should be compared with one another.
- Ensure stakeholders have the opportunity to review and reform the processes of public-private organizations tasked with reviewing quality metrics.

## Related Issues

- Sociodemographic Status
- Medicare Physician Payment and Quality

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**AAMC Government Affairs and Advocacy**  
[www.aamc.org/advocacy](http://www.aamc.org/advocacy)

**AAMC Hospital Payment and Quality**  
[www.aamc.org/hospitalpaymentandquality](http://www.aamc.org/hospitalpaymentandquality)

**Medicare Hospital Compare Website**  
[www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)

## ISSUE SUMMARY

Certain groups in the United States suffer from disproportionate levels of disease and death. These health differences are called health inequities/disparities. Ensuring safety net hospitals are not unfairly penalized in value-based purchasing programs, increasing federal funding for research focused on health inequities, and developing health professional and research career pathways for all regardless of race or income could help minimize or close these health inequities.

### Issue

Equity in health and health care in America continues to be a goal unmet. Certain demographic groups in the United States—including racial and ethnic minorities, veterans, the LGBTQ community, and individuals with a lower socioeconomic status—are less likely to get the preventive care they need to stay healthy, more likely to suffer from chronic illnesses such as diabetes and heart disease, more often living in neighborhoods where they are exposed to harmful environmental pollutants, and less likely to have access to optimal health care. In general, people in these demographic groups have poorer health outcomes across a wide array of diseases and higher all-cause mortality. These disparities have deep roots in the social determinants of health: the circumstances in which people are born, grow, live, work, and age. Yet despite our growing understanding of how factors at social, structural, and individual levels maintain and create inequities, solutions to reduce or eliminate them have been elusive.

### Background

Given the intransigence of health and health care inequities, reducing these systematic, avoidable differences in health between socially advantaged and disadvantaged groups has become a priority for providers, researchers, and policymakers alike. The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which is more than a decade old, documented pervasive disparities across the health care system and called for research-driven solutions and the dissemination and implementation of those solutions. The 2015 *National Healthcare Quality and Disparities Report* from the Agency for Healthcare Research and Quality suggests that progress has been minimal or absent.

The Affordable Care Act (ACA) contains numerous provisions with the power to reduce inequities in both health and health care. These include an improved collection of demographic

data, broader clinical and community-based prevention efforts, funding for community health grants, expanded health care access for underserved populations, and stronger commitments to workforce training for public health and clinical health care providers. The law also requires that not-for-profit hospitals conduct triennial community health needs assessments and set into motion changes in Medicare and Medicaid reimbursement and performance incentive policies for hospitals and physicians. These changes could further help reduce health care inequities as many of the value-driven payment models focus on preventable conditions that disproportionately affect racial/ethnic minorities and the poor.

Given that academic medical centers are more likely to care for complex patients living in underserved communities, issues of community health and health equity have taken on increased importance as reimbursement shifts from volume to value. Taking into account community- and patient-level factors that affect health outcomes and quality metrics is essential to ensure safety net hospitals are not unfairly stripped of the resources necessary to treat underserved patients and communities.

Additionally, to make inroads on improving the health and well-being of underserved populations, meaningful partnerships with local communities are paramount. Research efforts like the Precision Medicine Initiative, which aims to enroll a diverse sample of participants, will only succeed if trust develops between communities and scientists through authentic partnership. Similarly, local health programs are more likely to yield buy-in and uptake if developed in partnership with community stakeholders. Community-engaged science and scholarship require a culturally competent physician and biomedical research workforce. Cultural competence can only be achieved by a diverse set of health care and research professionals learning from one another's varied perspectives and experiences.

## AAMC Policy Recommendations

- Support adjustment for sociodemographic variables in hospital and physician quality metrics so safety net hospitals and physicians are not unfairly penalized for caring for complex patients discharged to underserved communities.
- Increase funding for National Institutes of Health (NIH) programs supporting solution-focused research aimed at building the evidence base of what works to close health and health care inequities.
- Continue support for NIH's Building Infrastructure Leading to Diversity (BUILD) and the National Research Mentoring Network initiatives to increase representation of underrepresented groups within the biomedical research workforce.
- Continue support for the efforts of the Health Resources and Services Administration (HRSA) under Title VII of the Public Health Service Act to improve the diversity, distribution, and supply of the health professions workforce with an emphasis on primary care and interdisciplinary education and training.

## Related Issues

- Health Professions Program (Title VII)
- Diversity and Inclusion
- National Institutes of Health
- Research Training and Workforce
- Health Care Quality
- Sociodemographic Status

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## Web Resources

**AAMC Information on Health Equity Research and Policy**  
[www.aamc.org/initiatives/research/healthequity](http://www.aamc.org/initiatives/research/healthequity)

### **AAMC Letter to the National Institute on Minority Health and Health Disparities (NIMHD)**

[www.aamc.org/download/437528/data/aamcsubmits\\_alettertonimhd.pdf](http://www.aamc.org/download/437528/data/aamcsubmits_alettertonimhd.pdf)

### **The State of Health Equity Research: Closing Knowledge Gaps to Address Inequities**

[www.aamc.org/initiatives/research/healthequity/402654/closingknowledgegaps.html](http://www.aamc.org/initiatives/research/healthequity/402654/closingknowledgegaps.html)

### **Community Health Needs Assessments:**

#### **Engaging Community Partners to Improve Health**

[www.aamc.org/download/419276/data/dec2014\\_communityhealth.pdf](http://www.aamc.org/download/419276/data/dec2014_communityhealth.pdf)

## ISSUE SUMMARY

Congress created the 340B Drug Pricing Program in 1992 to allow certain safety net hospitals (known as covered entities) to purchase outpatient drugs at a discount from drug manufacturers “to stretch scarce Federal resources” and expand health care services to vulnerable populations. In the decades of the program’s existence, the savings produced by the 340B program have become essential to hospitals as they struggle to meet the needs of the communities and patients they serve.

### Issue

Consistent with the original and continuing intent of the 340B program, AAMC-member teaching hospitals and their clinical faculty, residents, and students are committed to this safety net mission in expanding access to care for underserved and vulnerable patients. While they represent only 5 percent of all hospitals, major teaching hospitals account for 25 percent of all Medicaid discharges, 20 percent of all Medicare discharges, and 35 percent of the country’s charity care. Compared with physician offices and other hospitals, major teaching hospitals provide care to a higher proportion of low-income, dual-eligible, disabled, and minority patients. As major referral centers with highly specialized expertise, these academic medical centers (AMCs) serve a sicker, more complex, and more vulnerable patient population—patients who often are unable to seek the necessary care elsewhere. Hospitals use the savings from the 340B program to provide free or low-cost prescription drugs and to expand services and programs to low-income, uninsured patients.

### Background

The 340B program is administered by the Health Resources and Services Administration (HRSA). Other than modest appropriations to administer the program, the 340B program is self-sustaining in that the financial support hospitals receive is derived from drug manufacturer discounts, rather than through additional federal investments. Under the program, drug manufacturers offer lower prices on covered outpatient drugs to eligible hospitals (e.g., those with a Medicare disproportionate share percentage over 11.75 percent) and other settings, enabling these eligible entities to reinvest the difference in health care services for underserved and uninsured patients. The program accounts for just 2 percent of the annual drug purchases in the United States.

Through the savings generated from the 340B drug discounts from pharmaceutical companies, qualifying AAMC-member hospitals have been able to fund a wide range of programs to expand the provision of health care in their communities. For example, hospitals operate a variety of programs and services that otherwise would not be financially viable:

- Programs to provide free or substantially discounted prescriptions to uninsured or low-income patients
- Dialysis centers in low-income, underserved areas
- Smoking-cessation programs to help uninsured and underinsured patients gain access to cessation drugs
- Clinics that provide health care to underserved populations
- Mobile units for patients who are unable to visit a clinic
- Multidisciplinary clinics for patients discharged with mental health issues

In August 2015, HRSA released proposed omnibus guidance covering numerous provisions of the program. In its comments to HRSA, the AAMC expressed concern that the proposed guidance would pose substantial financial and operational challenges to hospitals participating in the program, restricting the scope of the 340B program in a manner that is inconsistent with long-standing HRSA policy and the underlying goals of the statute. A narrower 340B program likely would reduce access to patient care services supported as a result of the program, thus weakening its impact. The AAMC also noted that the proposed guidance would impose burdensome new requirements on participating hospitals that already are subject to strict and administratively complex program integrity requirements.

### AAMC Policy Recommendations

- The AAMC strongly supports the 340B program and opposes efforts to restrict the scope of the program. Under a narrower program, patients likely would lose access to services that are financially untenable without the savings generated by the 340B discounts.
- The AAMC welcomes the opportunity to garner additional clarity from HRSA about the program requirements. Guidance should strike the appropriate balance between feasible, clear requirements for all participants to demonstrate compliance and sufficient flexibility for providers so that the patients who are ultimately served by the program continue to benefit from it.

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### Web Resource

**AAMC October 2015 HRSA 340B Comment Letter**

[www.aamc.org/download/447362/data/aamcsubmitscommentson340bproposedomnibusguidance.pdf](http://www.aamc.org/download/447362/data/aamcsubmitscommentson340bproposedomnibusguidance.pdf)

## ISSUE SUMMARY

While regulation is necessary for safety and patient protection, hospitals, physicians, and other providers spend too much time and too many resources on unnecessary regulatory paperwork and compliance that divert from patient care. Many regulations were developed decades ago when reimbursement and delivery models were different. As the health care delivery system evolves, the AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations and recommends that any newly needed regulations be applied prospectively and have clear objectives.

### Issue

Academic medical centers (AMCs), which include clinical faculty providing care to patients at teaching hospitals, are leaders in delivering coordinated care for clinically complex and vulnerable patients while also performing innovative research and training the next generation of clinicians. Within this unique environment, AMCs must comply with federal regulations and policies. While a certain level of federal oversight is necessary, the government needs to reexamine and modify regulations that are limiting delivery system reform and innovation.

### Background

In recent years, health care delivery models have changed significantly. In January 2015, the Administration announced goals and an aggressive timeline for shifting Medicare reimbursements from quantity to quality and value. AMCs are increasingly moving to new ways to deliver care. As they, and all health care providers, respond to the new federal policies, the Centers for Medicare and Medicaid Services (CMS) must update its regulations and regulatory processes to reflect the new delivery system environment. Many regulations were developed years ago in the context of a fee-based reimbursement. A January 18, 2011, executive order (E.O. 13563) emphasizes the importance of reducing regulatory burden and costs. Specific regulatory actions that should occur to reduce unnecessary burden, improve care, and promote delivery reform are discussed below.

### Improve self-referral and anti-kickback regulations to accommodate delivery reform

To achieve the goals of delivery system reform, there is a need for changes to federal laws and regulations affecting hospital-physician arrangements, including the Physician Self-Referral Law (also known as “Stark”), the Anti-Kickback Law, and the Civil Monetary Penalties (CMP) Law. Since enactment of the self-referral law, there have been major changes in health care delivery and payment, including many initiatives to align payment with quality and to improve coordination of care. Provisions in these laws, which were enacted to address issues in a fee-for-service system, present significant barriers to clinical and financial integration aimed at improving the quality of care, population health, and reducing costs. The Office of Inspector General (OIG) of the Department of Health and Human Services should create a new safe harbor, and CMS should create a new Stark self-referral exception to enable financial arrangements that involve risk sharing and gain sharing in alternative payment models when appropriate safeguards are in place. These arrangements pose little risk of program or patient abuse and are intended to provide better quality care at reduced cost. Conditions set forth by the OIG and CMS for obtaining a waiver from the anti-kickback and self-referral laws for providers participating in the Bundled Payment for Care Improvement (BPCI) Model, the Shared Savings Accountable Care Organization (ACO) program, and the Comprehensive Care for Joint Replacement (CJR) Model could be used as criteria for a waiver.

### **Remove skilled nursing facility three-day hospital stay rule, pay for telehealth services in more locations, and waive direct supervision requirement for home visits**

To better coordinate and improve care for patients, CMS should allow waivers of the three-day skilled nursing facility (SNF) rule, which requires that a patient spend three days as a hospital inpatient before being eligible for SNF services. This requirement is an impediment for providers trying to reduce costs and improve quality. For some patients, the most appropriate care is at an SNF after a short hospitalization or an observation stay. Yet, currently, selecting the most appropriate care means that the SNF stay would not be covered by Medicare.

The general Medicare rules related to payment for telehealth services require that the services be provided to a patient in a rural area and at an originating site defined by CMS. The home is not included as an originating site. Patients in urban and other areas who do not have convenient access to a provider could also benefit from telehealth. Certain alternative payment models (APMs), such as Next Generation ACOs, have telehealth waivers available, but such waivers should also be provided to other APMs.

CMS should waive the direct supervision requirement for postdischarge home visits so that nurses could provide services, without a physician present, in the homes of beneficiaries who are not homebound.

As Medicare payments move toward having a strong quality component, there is little risk that these changes would result in services being used for other than the best quality, most cost-efficient care. CMS should eliminate policies that impede good care and could result in financial penalties for both providers and patients.

### **Align quality measures across payers**

The number of quality measures that providers must report to CMS and other payers is increasing rapidly in the inpatient and outpatient quality programs. CMS should align the measures used by both the Medicare and Medicaid programs as well as commercial payers to reduce burden and prevent confusion. A key step would be development of a national core measure set, with measures that apply across health settings and across payers. CMS should focus on measures that are critical to driving the best possible outcomes for patients.

### **Prevent inconsistent and duplicative audits**

Medicare subjects providers to claims review by multiple entities including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Comprehensive Error Rate Testing Contractors (CERT). These redundant and overlapping audits place an enormous burden on providers and have resulted in inappropriate denials. There is a need to streamline and eliminate these duplicative audits.

### **AAMC Policy Recommendations**

- The AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations.
- The AAMC recommends that any new regulations be limited in scope and, if necessary, be applied prospectively and have clear objectives.
- Specific regulatory areas that a new administration should review and address include fraud and abuse regulations that restrict new delivery models, inconsistent and duplicative audits, alignment of quality measures, waivers of the SNF three-day stay, expansion of payment for telehealth services, and home visits requirements.

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## ISSUE SUMMARY

The ability of the U.S. health care system to respond to natural and human-induced disasters depends heavily on teaching hospitals, their facilities, and their staffs and affiliated teaching physicians. Maintaining emergency preparedness, and responding when an emergency occurs, benefits the entire community but also generates substantial expenses. Many of these costs are borne by teaching hospitals. For communities and the nation to be adequately prepared requires ongoing, stable financial support for academic medical centers.

### Issue

Medical schools and teaching hospitals are pioneers in treating complex conditions; advancing medical discoveries for better diagnostics, preventive strategies, and treatments; educating the next generation of physicians; and providing irreplaceable community services. The nearly 400 nonfederal major teaching hospitals and health systems represented by the AAMC are complex institutions with more surge capacity (i.e., the ability to manage a sudden influx of patients) and specialized treatment capabilities than most acute care hospitals. As a result, the tripartite mission of research, education, and patient care uniquely qualifies academic medical centers in preparing for and responding to unexpected threats such as Ebola and Zika, as well as daily challenges such as influenza.

### Background

Though major teaching hospitals make up only 5 percent of all hospitals, they provide the vast majority of the nation's critical standby and highly specialized services. For example, 71 percent of the nation's Level I trauma centers are at AAMC-member institutions. As a result, these institutions serve as regional referral centers for the most complex patients. The infrastructure afforded by these well-established referral patterns and highly specialized expertise at academic medical centers strengthens the ability of the nation's health care system to respond expeditiously to novel threats.

At the same time, the ability to respond to these catastrophic events depends on a robust and continuing investment in standby costs for resources needed to ensure that, at a moment's notice, a hospital can respond to an unanticipated event. This investment keeps surgeons, operating rooms, blood supplies, and many other key personnel and facilities available for immediate use in the case of an event that affects the health of a community or, in the case of Ebola, the health of the nation.

Consider, for example, the expenses associated with providing the highest level of trauma care through Level 1 trauma centers. To earn and maintain this designation, they must ensure immediate on-site access to a full team of surgical and other specialists, lab and radiological staff, and other providers. They must be equipped to treat a full spectrum of injuries at any time and prepared to accept transfers from other settings that can only provide initial care. These specialized capabilities are critical in an emergency—according to the Centers for Disease Control and Prevention (CDC), severely injured patients who receive care at a Level I trauma center have a 25 percent better chance of survival than those who receive care elsewhere—but these capabilities carry a sizeable price tag even when they are not in use.

As a result of their experience in caring for the most complex patients and in administering research protocols, major teaching hospitals were able to gear up immediately when it became clear that treating Ebola required unique and extensive preparedness that could be found at teaching hospitals. For over a decade, two AAMC-member institutions have maintained specially built isolation units to treat patients with serious infectious diseases—at the time, two of only three ready units in the country. The institutions invested substantially to conduct regular training exercises and maintain constant readiness, despite losing funding from other sources. After treating the first Ebola patients in the United States, they made it a priority to share the knowledge they gained with state and federal health officials, other facilities in the United States, and health professionals globally. Ultimately, AAMC-member teaching hospitals comprised 90 percent of the Ebola treatment centers designated by the CDC in collaboration with state health officials and also played a central role in advancing important research toward potential vaccines, diagnostics, and treatments for Ebola.

The capacity of academic medical centers to respond successfully to Ebola was facilitated by the nation's long-standing commitment to supporting medical schools and teaching hospitals. While emergency supplemental funding is frequently necessary in such situations to offset some unique expenses and meet facilities' immediate needs, sustaining that level of preparedness over the long term requires institutional financial commitments that persist long after supplemental funding is exhausted. The Hospital Preparedness Program (HPP), administered by the Office of the Assistant Secretary for Preparedness and Response (ASPR) within the Department of Health and Human Services (HHS), is an important source of dedicated funding for such efforts, but its budget today is less than half the funding level in fiscal year (FY) 2003 when the program peaked at \$515 million.

Additionally, ongoing investments in the missions of academic medicine will be essential to ensure medical schools and teaching hospitals can preserve the infrastructure that allows them to scale up immediately in emergency situations. Maintaining specialized treatment facilities—including trauma centers, decontamination units, advanced life support care, burn units, and other services and facilities—is part of the core patient care mission of major teaching hospitals, as is educating the physicians and other health professionals who staff them. The added benefits provided by teaching hospitals to the community mean that faculty physicians, teaching hospital staff, and physicians in training are available as frontline responders during a public health crisis, providing an invaluable resource to those who need immediate care during an emergency and serving as vital partners to the broader public health community.

### AAMC Policy Recommendations

- Stable, ongoing funding to support the missions of medical schools and teaching hospitals is essential to ensure they can maintain the physicians, staff, and services required to respond to emergencies, whether the emergencies are limited to the institution's community or threaten the health of the nation.
- The AAMC supports robust, continued funding for HPP within ASPR. Designated funding from ASPR to support hospitals directly will be a key component to ensuring ongoing preparedness.
- A system for public health funding that only takes the nation from crisis to crisis fuels major vulnerabilities in the country's preparedness. The AAMC supports a strong investment in the nation's core public health and health care infrastructure and swift access to designated emergency supplemental funds, as necessary. Repurposing existing investments to address new threats will only weaken efforts.

### Related Issues

- Medicare Mission Payments
- National Institutes of Health

### AAMC Contact

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### Web Resources

**Academic Medicine's Three Missions of Research, Education, and Patient Care Are Critical to Ensuring Preparedness**

[www.aamc.org/download/446672/data/academicmedicines-threemissionsofresearcheducationandpatientcare.pdf](http://www.aamc.org/download/446672/data/academicmedicines-threemissionsofresearcheducationandpatientcare.pdf)

**Triumph Over Tragedy: Academic Medicine's Vital Role in Providing and Advancing Trauma Care**

[www.aamc.org/download/335876/data/academicmedicines-vitalroleinprovidingandadvancingtraumacare.pdf](http://www.aamc.org/download/335876/data/academicmedicines-vitalroleinprovidingandadvancingtraumacare.pdf)

## ISSUE SUMMARY

In January 2015, the Obama Administration announced the ambitious goal of shifting 30 percent of traditional Medicare Fee-for-Service (FFS) reimbursement to alternative payment models by the end of 2016, and 50 percent by the end of 2018. AAMC-member teaching hospitals have been very involved in Medicare alternative payment models. The AAMC believes that for these models to continue their success, they should include appropriate risk adjustment methodologies to ensure that providers, such as teaching hospitals and physicians, that treat the most complex individuals are not unfairly penalized. The methodologies also should incentivize providers for elements they can control, rather than penalizing providers for the factors they cannot influence. This point is especially crucial for academic medical centers (AMCs), which often care for the most complex and vulnerable patients. Finally, the payment methodologies should exclude Medicare mission-related payments so that savings calculations appropriately reward the reduction of unnecessary services.

### Issue

In January 2015, Health and Human Services Secretary Sylvia Mathews Burwell announced the Administration's ambitious goal of shifting 30 percent of traditional Medicare FFS reimbursement to alternative payment models by the end of 2016, and 50 percent by the end of 2018. In March 2016, the Administration announced that it had met the first goal, nearly one year ahead of schedule. This expedited achievement is primarily due to the rapid uptake of Medicare value-based care models (VBCMs), such as accountable care organizations (ACOs) and bundled payment programs. As an example, under a retrospective bundled payment program, providers are assigned a budget for the totality of a patient's care for a given clinical condition over a set period of time. If actual payments exceed the target budget, the provider must pay back the difference to Medicare. However, if actual payments fall below the budget, the provider receives the difference as savings. Medicare designed such programs with the intention of incentivizing the delivery of high-quality, efficient care.

The first of these models, Bundled Payments for Care Improvement (BPCI), was introduced in 2012. AMCs were among the early entrants in this program. The launch of the mandatory joint replacement bundled payment program, Comprehensive Care for Joint Replacement (CJR) on April 1, 2016, and the Oncology Care Model (OCM) on July 1, 2016, will both drastically increase

the number of providers in risk-based payment models. Finally, in July 2016, the Centers for Medicare and Medicaid Services (CMS) announced three new bundled payment models in the proposed rule, Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR). Providers in these models all face a need for enhanced data analytics, education regarding new gainsharing opportunities and complex payment policies, and assurance that their needs will be reflected through effective advocacy. Planning and implementing an alternative payment model requires involvement from both administrative and clinical leadership, as well as significant time and resources. In many instances, CMS has not provided adequate time or support for these endeavors.

### Background

Since 2012, the AAMC has served as a facilitator convener in BPCI, and the number of convened group members has grown to 30 hospitals. In 2016, the AAMC also introduced collaboratives for hospitals participating in CJR and OCM. In these roles, the AAMC provides policy and data analytic support to hospitals implementing bundled payments, in addition to working with CMS to address policy concerns and shape the development of these models. The association also facilitates shared learnings between members.

A key component of many of these models is the establishment of spending “benchmarks” or “target prices” and the comparison of those amounts with actual spending levels. CMS has excluded the mission payments received by teaching hospitals (the indirect medical education [IME] and disproportionate share hospitals [DSH] adjustments) in the calculations for several of the ACO models. This decision is important because if these payments were included, ACO providers that had previously used teaching hospitals would have an incentive to begin sending their patients to other hospitals to generate savings. CMS has stated that removing IME and DSH payments from benchmark and performance year expenditures would allow Medicare to “more accurately reward actual decreases in unnecessary utilization of healthcare services, rather than decreases arising from changes in referral patterns.”

### AAMC Policy Recommendations

The AAMC believes that a number of modifications could be made to APMs that would encourage long-term participation by providers and ensure high-value, high-quality care for patients. These include appropriate risk adjustment methodologies to ensure that providers, such as teaching hospitals and physicians, that treat the most complex individuals are not unfairly penalized. The methodologies also should incentivize providers for elements they can control rather than penalize providers for the factors they cannot influence. This point is especially crucial for AMCs, which often care for the most complex and vulnerable patients. Finally, the payment methodologies should exclude Medicare mission-related payments so that savings calculations appropriately reward the reduction of unnecessary services.

- Treatment of direct graduate medical education (DGME), IME, and other Medicare add-on payments: Add-on payments for DGME, IME adjustment, outlier payments, and DSH adjustment should be excluded from target price calculations as well as actual performance period payments. Such a policy ensures that providers are rewarded for changing how they practice rather than for changing referral patterns, which could be detrimental to patients.
- Appropriate risk adjustment: Payments and quality measures must be appropriately adjusted to reflect the higher complexity of patients treated by teaching hospitals and academic physicians.

- SDS adjustment: Payment and quality measures must be adjusted so as not to penalize providers for factors that are beyond their control.
- Early and frequent access to Medicare claims data: Medicare provides historical and performance period claims data to participants in the various models. Participants use these data to identify clinical and financial areas of risk and opportunity and to inform their overall implementation strategy.
- Accurate and predictable target prices: Medicare must employ target price methodologies that limit variation in target across time and ensure that providers are assigned targets that present accurate and fair benchmarks for financial performance.
- Adequate transition to downside risk: Providers require considerable time to plan and implement alternative payment models. Many BPCI participants, who voluntarily entered this model, spent at least a year preparing for the risk phase. Medicare must provide participants—especially those in mandatory models—with a gradual ramp to accepting downside risk. This end can be achieved by including an upside-only phase and by using higher target prices.
- Waivers: Waivers of certain Medicare payment rules and fraud and abuse rules are necessary to successfully implement alternative payment models.

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### Web Resource

#### AAMC Information on Alternative Payments

<https://www.aamc.org/initiatives/bundling>

The AAMC is the authoritative source for the most comprehensive data on academic medicine, including medical education across the continuum, highly specialized clinical care at major teaching hospitals that serve vulnerable patient populations, and cutting-edge medical research conducted at AAMC-member institutions. The sampling of AAMC reports and publications described below provides additional information about the academic medicine community and its mission to improve the health of all. For more information about these or other resources, please contact the listed AAMC staff member or the AAMC Government Relations office at 202-828-0525.

## Diversity and Inclusion

### **Altering the Course: Black Males in Medicine**

- Focuses on the decline in the number of African-American males applying to and accepted by medical schools over the last three decades.
- Contact: Clayton Crabtree, ccrabtree@aamc.org, 202-739-2995

### **Diversity in the Physician Workforce: Facts and Figures 2014**

- Provides data on the physician workforce, sorted by race, ethnicity, age, and gender.
- Contact: Clayton Crabtree, ccrabtree@aamc.org, 202-739-2995

### **The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership, 2013–2014**

- Examines the current status of women in the ranks of academic medicine and the paths to increasing their representation in leadership positions.
- Contact: Matthew Shick, mshick@aamc.org, 202-828-6116

## Physician Training and Graduate Medical Education (GME)

### **Becoming a New Teaching Hospital: A Guide to the Medicare Requirements**

- Describes the federal requirements for becoming a new teaching hospital and how to become eligible for direct graduate medical education and indirect medical education payments under the Medicare program.
- Contact: Len Marquez, lmarquez@aamc.org, 202-862-6281

### **Medicaid Graduate Medical Education Payments: A 50-State Survey**

- Survey of state Medicaid programs and policies for financing GME.
- Contact: Len Marquez, lmarquez@aamc.org, 202-862-6281

### **Rural Training Track Programs: A Guide to the Medicare Requirements**

- Outlines the ways rural and urban hospitals forming partnerships to train residents in rural areas can add Medicare-funded training slots through a Rural Training Track program.
- Contact: Len Marquez, lmarquez@aamc.org, 202-862-6281

### **Report on Residents**

- Collection of data tables that provide information on certain characteristics of residency applicants and residents, as well as information on postresidency professional activities.
- Contact: Matthew Shick, mshick@aamc.org, 202-828-6116

## Medical Education

### MedEdPORTAL

- The AAMC's free, open-access publication service to equip health professions educators across the continuum with effective and efficient curricular materials and educational tools to improve instruction and patient care.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers (2016)

- Statistical abstract of U.S. medical schools and teaching hospitals with current and historical data on a comprehensive list of topics including physicians, health care financing, teaching hospitals, tuition, financial aid, student debt, medical school revenue, medical school applications, and many others.
- Contact: Len Marquez, [lmarquez@aamc.org](mailto:lmarquez@aamc.org), 202-862-6281

### Medical Student Education: Debt, Costs, and Loan Repayment Fact Card, October 2015

- Data on the costs of medical education for students, differentiating between the costs and indebtedness of public versus private medical school education.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### Medical School Graduation Questionnaire (GQ)

- Survey of all graduating medical students providing data on topics such as preclinical, clinical, and elective experiences, general medical education, and other topics for schools to use in program evaluation and to improve the medical student experience.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### Matriculating Student Questionnaire (MSQ)

- Questionnaire administered to all first-year medical students on topics such as premedical experiences, medical school selection processes, and future career interests.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### Physician Education Debt and the Cost to Attend Medical School, 2012 Update

- Report that outlines analyses of medical school costs, the education debt of medical school graduates, and borrowing conditions for medical students, among other topics.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### Results of the 2015 Medical School Enrollment Survey

- Report that examines first-year medical school enrollment over the past decade, projects first-year enrollment through 2025, and describes some recruitment initiatives underway at medical schools.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

## Physician Workforce

### Complexities of Physician Supply and Demand: Projections from 2014 to 2025 (2016 Update)

- Annual publication analyzing the size and composition of the nation's physician workforce in 2025, prepared by IHS Inc., a global forecasting firm.
- Contact: Matthew Shick, [mshick@aamc.org](mailto:mshick@aamc.org), 202-828-6116

### Physician Specialty Data Book 2014

- Publication that provides data on active physicians and physicians in training in the specialties with the largest number of active physicians in the United States.
- Contact: Matthew Shick, [mshick@aamc.org](mailto:mshick@aamc.org), 202-828-6116

### Well-Being in Academic Medicine Website

- AAMC website that synthesizes information about conferences, workshops, publications, and other resources that address physician well-being and resilience at a time of concern about stress and burnout among students, residents, physicians, and faculty.
- Courtney Summers, [csummers@aamc.org](mailto:csummers@aamc.org), 202-862-6042

### State Physician Workforce Data Book 2015

- Compendium of state level data on the physician workforce, such as the current physician supply, medical school enrollment, GME, and retention.
- Contact: Matthew Shick, [mshick@aamc.org](mailto:mshick@aamc.org), 202-828-6116

## Medical Research and Innovation

### **AAMC Conflicts of Interest (COI) Metrics Project**

- Presents findings on the impact of specific changes to the U.S. Department of Health and Human Services regulations on conflicts of interest in federally funded research, using data collected from AAMC-member institutions.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### **Academic Medicine Investment in Medical Research**

- Presents findings on the comprehensive investment in medical research across 46 medical schools surveyed, estimating that academic medicine invests 53 cents for every \$1.00 of sponsored research funding received.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

### **National MD/PhD Program Outcomes Study**

- Provides the results of an AAMC national study on the career paths of physician scientists who have graduated from MD/PhD programs over the past five decades.
- Contact: Tannaz Rasouli, [trasouli@aamc.org](mailto:trasouli@aamc.org), 202-828-0057

In addition to the reports and resources in the previous section, there are also opportunities to get involved in activities to support medical schools and teaching hospitals, including having members of Congress join the Congressional Academic Medicine Caucus or attending a Project Medical Education conducted by individual medical schools and teaching hospitals.

### Congressional Academic Medicine Caucus

The Congressional Academic Medicine Caucus (CAMC) is an informal, bipartisan group of members of Congress dedicated to maintaining and strengthening our nation's reputation for having the world's most advanced medical care. CAMC members strive to educate their colleagues on the unique health care, research, and training missions of teaching hospitals and medical schools. Working in close collaboration with the AAMC, the CAMC has sponsored numerous educational briefings on Capitol Hill with representatives of medical schools, teaching hospitals, and others in the academic medical community to discuss trauma care, rural workforce shortages, academic medicine's response to Ebola, hospital performance measurement, workforce shortages within the Department of Veterans Affairs, and many other critical issues.

Contact: Courtney Summers, [csummer@aamc.org](mailto:csummer@aamc.org), 202-862-6042

### Project Medical Education

Project Medical Education (PME) is an intensive, one-and-a-half day interactive learning program, organized by an academic medical center in collaboration with the AAMC, that informs policymakers and their staff, community leaders, donors, and others about the missions and work of medical schools and teaching hospitals. Through hands-on sessions, in which participants assume the roles of medical student, resident physician, faculty physician, and researcher, participants learn what it takes to become a physician; how academic medical centers fulfill their three-fold missions of providing extraordinary clinical care, medical education, and scientific research; and how local, state, and national governments contribute to this process.

Contact: Jared Dashoff, [jdashoff@aamc.org](mailto:jdashoff@aamc.org), 202-828-0441



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