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July 11, 2019

The Honorable Anna Eshoo
Chairwoman
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Burgess, MD
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

The Association of American Medical Colleges (AAMC) welcomes the opportunity to submit this letter regarding the House Energy and Commerce Subcommittee on Health's July 11 markup. The AAMC greatly appreciates that the Subcommittee is working in a bipartisan manner to address key health care issues. We support the legislation to eliminate the scheduled Medicaid Disproportionate Share Hospital (DSH) cuts in fiscal years (FYs) 2020 and 2021. We also appreciate reauthorization of the Patient-Centered Outcomes Research Institute (PCORI) and the Title VII health care workforce development grant programs, as well as funding for the National Health Service Corps (NHSC) and Teaching Health Centers (THC). While we recognize the importance of addressing surprise medical bills, we remain opposed to the Subcommittee's current proposal to use benchmark rate setting as the solution to this problem.

The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited 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. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

**Medicaid Disproportionate Share Hospital Program**

The AAMC strongly supports the Subcommittee's amendment to H.R. 2328, which would eliminate the scheduled Medicaid DSH cuts for FYs 2020 and 2021 and reduce the cuts in FY 2022, thereby sparing safety net hospitals, many of which are teaching hospitals, $16 billion in unsustainable Medicaid reductions. We also appreciate the Subcommittee's efforts to lessen the FY 2022 reduction from $8 billion to $4 billion.

Without congressional action, effective Oct. 1, 2019, safety net hospitals across the country will incur $4 billion in Medicaid DSH cuts, threatening services to the most vulnerable communities. The cuts are scheduled to double to $8 billion per year in FYs 2021-2025, totaling $44 billion over the six-year period. These reductions are untenable and would inevitably force safety net hospitals to reduce critical health care services.

The Medicaid DSH program was created in 1985 to help hospitals offset two types of uncompensated care: Medicaid shortfalls and unpaid costs of providing care to uninsured individuals. AAMC-member teaching hospitals provide a disproportionate amount of care to Medicaid patients and provided nearly $10.5 billion in uncompensated care in 2017. Cuts to Medicaid DSH funding would be particularly harmful to these hospitals, which rely on the funding to provide access to critical services to all vulnerable patients, including those with the most complex medical conditions.

In May, over 300 members of the House sent a letter to Speaker Nancy Pelosi (D-Calif.) and Minority Leader Kevin McCarthy (R-Calif.) urging them to address the Medicaid DSH cuts for at least two years until a more sustainable, permanent solution is reached.

The AAMC greatly appreciates the Subcommittee's bipartisan response and supports this proposal to eliminate a significant portion of the scheduled Medicaid DSH cuts.

**Surprise Medical Bills**

The AAMC agrees that surprise medical bills must be addressed and is pleased to see that H.R. 3630 would take patients out of the middle in surprise billing situations. However, the AAMC asks the Subcommittee to reconsider rate setting, as it stands to negatively impact academic medicine and teaching hospitals. Statutory rate setting will disincentivize insurers to negotiate with providers, and instead allow them to use statutory benchmarks to negotiate rates with providers. Not only does this undermine the fundamental practice of private negotiation, but it will lead to narrow networks – which oftentimes limit patient access to needed health care services and providers – as health plans will lose incentive to offer competitive rates and fair business practices to encourage providers to enter into contracts.

The AAMC is specifically concerned that statutory rate setting stands to potentially limit beneficiary access to academic medical centers due to the higher mission-related costs of care at many of these facilities without recognizing the higher quality. Major teaching hospitals and medical schools are a critical component of the US health care system because of their joint missions of patient care, medical research, and education that benefit the health care of all. While only 5% of all hospitals, AAMC's member teaching hospitals account nationwide for 24% of all Medicare inpatient days, 25% of Medicaid inpatient days, 31% of all hospital charity care costs, 21% of all psychiatric beds, 61% of all pediatric intensive care beds, 71% of all Level 1 trauma centers, and 96% of all NCI registered cancer treatment centers. They also are responsible for about three-quarters of the physician residency training in this country as well as over half of

NIH extramural research funding. These missions create an environment that offers irreplaceable expertise and services to which everyone should have access. Therefore, the AAMC strongly urges the Subcommittee to reconsider this proposal, as it would destabilize academic medicine and workforce training by allowing insurers to use benchmark payments as leverage to pay academic medical centers less, or to justify cutting them out of networks completely. The Subcommittee should preserve the process of rate negotiation between providers and insurers.

The AAMC suggests that the Subcommittee explore other options for resolving disputes between payers and providers. Given the success of the state law in New York, the AAMC believes that the Committee should consider an independent dispute resolution, or arbitration, process. We believe that this may be the most expeditious and fair way to resolve billing disputes.

**Patient-Centered Outcomes Research Institute**

The AAMC strongly supports PCORI and appreciates that the Subcommittee on a bipartisan basis recognizes the need to continue this important institute and its funding mechanism. While the markup represents an important step in moving a reauthorization forward, we are concerned that the legislation under consideration by the Subcommittee only would extend funding for the institute's work for three years.

The duration of PCORI research awards is five years; a second phase of awards after the project is complete supports dissemination of the initial projects' outcomes. Given this structure, a three-year reauthorization would create uncertainty that could limit the ability of the institute to pursue new research projects and hamper subsequent implementation efforts. The unique infrastructure that PCORI has established to conduct clinical comparative effectiveness research and the explicit focus on dissemination make the institute particularly vulnerable to the disruptiveness that would ensue from a short-term reauthorization.

To maximize the stability necessary to carry out PCORI's mission, more than 170 organizations across the stakeholder community have urged lawmakers to pursue a reauthorization that renews PCORI's initial 10-year authorization for at least another 10 years. We hope, as the process moves forward, to continue to work with the Subcommittee and other lawmakers toward this important goal.

**National Health Service Corps**

The NHSC is widely recognized — both in Washington and in the underserved areas it helps — as a success on many fronts. The simple, yet historically effective design of scholarship and loan repayment in exchange for primary care service in underserved communities:

- improves access to health care for the growing numbers of rural and urban underserved Americans;
- increases state investments in recruiting health professionals;

- provides incentives for practitioners to enter primary care;
- reduces the financial burden that the cost of health professions education places on new practitioners; and
- helps promote access to health professions education for students from all backgrounds.

Given its success in improving the distribution of the primary care workforce, the AAMC supports the NHSC as part of a multipronged approach to help improve access to health care in underserved communities.

While the AAMC supports the Subcommittee's efforts to reauthorize mandatory funding for the NHSC beyond FY 2019, we echo the Friends of the NHSC in calling for a doubling of the NHSC field strength to eliminate Health Professions Shortage Areas nationwide. For FY 2020, we recommend a total of $475 million for the NHSC, including both annual appropriations and the NHSC mandatory fund. This $60 million (15%) increase is the first stage of a five-year systematic doubling of the NHSC to meet the needs of underserved communities.

**HRSA Title VII Health Professions Workforce Development Programs**

The AAMC also supports the Educating Medical Professionals and Optimizing Workforce Efficiency Readiness (EMPOWER) for Health Act of 2019 (H.R. 2781) to reauthorize the HRSA Title VII health professions workforce development programs.

The Title VII health professions programs are a petri dish for innovation that prepare our current and future physician workforce to respond to the nation's constantly changing health care needs. Title VII programs increase the supply, distribution, and diversity of the health care workforce and improve access to and quality of care for vulnerable populations — including children and families living on low incomes, veterans, seniors, and individuals in underserved communities.

As physician workforce shortages are projected to grow across all specialties, Title VII programs help fill the supply of health professionals not met by traditional market forces by providing scholarships, loan repayment programs, and grants to academic institutions, students, and non-profit organizations,

We appreciate the Subcommittee's efforts to reauthorize the Title VII programs under the EMPOWER for Health Act to ensure these programs continue to help shape our health care workforce. At the same time, we continue to urge appropriators to provide at least $424 million for the current Title VII programs in fiscal year 2020.

**Teaching Health Centers**

The AAMC supports the Subcommittee's efforts to reauthorize the mandatory appropriations fund for the THC program through HRSA, given the other complementary health professions workforce development programs administered by the agency. In a time of existing and

anticipated physician shortages, lawmakers should ensure that we are preserving and enhancing the nation's commitments to the full array of federal physician training programs.

**Addressing the Medicare Residency Caps**

In addition to challenges with maldistribution of physicians in underserved areas, the AAMC projects that the United States will see a shortage of up to 122,000 physicians by 2032, in both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Increasing federal investments in graduate medical education is critical to meeting the nation's growing physician workforce demands. Aside from the targeted workforce programs under consideration by the Subcommittee at this markup, the AAMC also strongly supports legislation to end the two-decade freeze on Medicare support for graduate medical education.

The NHSC and THC programs play an important role in addressing primary care needs in underserved communities. However, the size and breadth of projected physician workforce shortages cannot be solved by recruitment and training location alone. The major factor driving demand for physicians continues to be a growing, aging population. With the demand for physicians simply outstripping our expected supply, we must advance a multifaceted strategy to ensure that Americans have access to the care they need when they need it. The AAMC strongly supports the bipartisan Resident Physician Shortage Reduction Act of 2019 (H.R. 1763, S. 348) as a critical component of any comprehensive workforce strategy to strengthen the physician workforce in both primary and specialty care by lifting the current freeze to support 3,000 new residency positions each year for the next five years.

**Other Legislation of Interest**

The AAMC applauds the Subcommittee's inclusion of the Fair Accountability and Innovative Research Drug Pricing Act of 2019 (FAIR Drug Pricing Act, H.R. 2296) and the Subcommittee's efforts to ensure stable and predictable funding for quality measurement activities carried out by the National Quality Forum.

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Thank you for considering these comments. We appreciate the Subcommittee's efforts to address a wide range of important health care issues and look forward to continuing to work with you.

Sincerely,

Karen Fisher, JD
Chief Public Policy Officer