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AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

January 16, 2015

The Honorable Joe Pitts
Chairman, Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Gene Green
Ranking Member, Health Subcommittee
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Energy & Commerce Committee
U.S. House of Representative
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Peter Welch
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable H. Morgan Griffith
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Kathy Castor
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pitts, Ranking Member Pallone, Ranking Member Green, and Representatives DeGette, McMorris Rodgers, Welch, Griffith, and Castor:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), we welcome the opportunity to respond to the Open Letter Requesting Information on Graduate Medical Education (GME) from December 6, 2014. AACOM represents the 30 accredited colleges of osteopathic medicine (COMs) in the United States. These colleges are accredited to deliver instruction at 42 teaching locations in 28 states.

AACOM would like to express strong support for the Committee's willingness to explore the GME system in an effort to improve access to and delivery of health care services by ensuring a well-trained physician workforce. Given the numerous challenges currently facing the U.S. health care system – the changing role of the physician in health care; a rapidly evolving and diverse patient population; a health care system undergoing transformation; a physician workforce shortage that is projected to worsen over the coming years; and the rising number of medical school graduates facing a finite number of residency slots, thoroughly assessing GME to ensure the continued delivery of high-quality health care has never been more critical.

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

AACOM would like to highlight the strong connection between osteopathic medical colleges' training of students, which is patient-centered and was developed with a foundation of primary care training in community-based settings, and osteopathic GME programs, which are linked through the oversight of an Osteopathic Postdoctoral Training Institution (OPTI) — a consortium of partnerships among one or more teaching hospitals, an osteopathic medical school, and other medical training facilities. These OPTIs create a learning environment that connects community-based institutions, practicing physicians, and medical education programs in a framework that produces physicians in the communities in which they will deliver the kind of patient-centered care needed in the evolving U.S. health care system.

AACOM requests that the Committee modify the legislative and regulatory barriers that continue to hinder efficiency, growth, and innovation of GME and other aspects of the medical education continuum. Training students in a distributive model and utilizing community resources has been the hallmark of osteopathic clinical education; OPTIs tie the undergraduate training in hospitals to graduate training. This type of integration of the undergraduate and the GME curriculum results in more efficient training of physicians as well as more efficient use of hospital and educational resources, thus strengthening our current GME system. Although AACOM continues to support lifting the Centers for Medicare & Medicaid Services (CMS) cap put in place by the *Balanced Budget Act of 1997* on Medicare-funded GME slots, we also support exploring other models of GME funding both under and outside of CMS.

The report from the Institute of Medicine's (IOM) Committee on the Governance and Financing of GME identifies changes that could improve GME by simplifying payment, adding new infrastructure, increasing accountability and transparency, and developing outcome measures that better align GME with national health care needs. These proposals provide a benchmark for a comprehensive discussion of GME as the existing system is assessed and changes are considered for its improvement. For example, AACOM believes that the IOM's call for an adjusted per-resident amount (PRA) as a basic GME financing mechanism is worthy of consideration as a means of providing greater equity of financing and incentives for innovation, efficiency, and flexibility. However, we believe that such consideration should be undertaken with the caution necessary to avoid unintentional disruption of existing training programs and unintended consequences to the patients served by the institutions housing these programs.

AACOM agrees with the IOM's finding that the current Medicare-GME system does not adequately prepare trainees to practice in all venues where they are mostly likely to care for patients. With nearly 90 percent of medical care rendered in ambulatory settings, the current structure of GME financing should be reviewed closely to better enable training to occur in these settings. Training environments that include non-hospital settings and flexibility for innovation with the long-term financing necessary to enable adequate evaluation of program outcomes should be supported. Additionally, AACOM strongly believes that any effort to reform GME must address the need for transparency, as well as enable expansion of Medicare-funded GME positions in alignment with the physician workforce needs of the currently-transforming health care system.

2. **There have been numerous proposals put forward to reform the funding of the GME system in the United States. Are there any proposals or provisions of proposals you support and why?**

AACOM believes there are innovative solutions to address the challenges in the current GME system. Accreditation requirements for osteopathic medical schools mandate that each school must provide medical care to the community in which its students learn, and the current osteopathic medical education model links the osteopathic medical schools' training to the communities in which students are trained. Similarly, the number and distribution of GME positions could be tied to the number and type of positions needed, with some consideration for geographic, demographic, and specialty need; the development of more programs with hospitals in these locations could fall outside of the GME cap. Furthermore, there should be a continued expansion and sustainable funding of the Health Resources and Services Administration's (HRSA) Teaching Health Center GME (THCGME) Program, which provides funds to establish or expand primary care medical and dental residency training programs in community health centers. Additionally, we would like to highlight for the Committee the attention being focused on GME examination and reform by groups ranging from the Josiah Macy Jr. Foundation (see Ensuring an Effective Physician Workforce for the United States: Recommendations for Graduate Medical Education to Meet the Needs of the Public) to HRSA's Council on Graduate Medical Education (COGME).

The THCGME Program

AACOM supports the evaluation of Medicare-GME funding as it relates to need and also supports expanded flexibility of current funding to create an environment in which innovation can occur. Innovation, partnership, and the targeting of resources should help address need. For example, the HRSA THCGME Program, established in the *Affordable Care Act* (P.L. 111-148) and currently in its final year, provides a strong model of innovation. This model produces primary care physicians in the communities in which they are most needed and sets a strong precedent to fund GME outside of the traditional CMS-funding stream to create new avenues for training medical residents in community-based, non-hospital settings. Sixty programs are currently operating around the country, providing residency training in dentistry, family medicine, internal medicine, obstetrics and gynecology, pediatrics, and psychiatry.

Teaching Health Centers (THCs) provide primary care medical and dental training opportunities in community-based settings, with more than 550 residents providing much-needed health care to thousands of patients annually in urban and rural communities. Funded through grant dollars administered by HRSA, these programs are mandated to meet strict accountability requirements in which every federal dollar is used exclusively for primary care training. Of the 60 programs currently funded, more than half are either osteopathic programs accredited by the American Osteopathic Association (AOA) or are dually-accredited (D.O./M.D.) by both the AOA and the Accreditation Council for Graduate Medical Education (ACGME).

Sustainability for programs such as these is critical in addressing physician workforce needs, as these programs have the potential to greatly increase the number of primary care physicians that serve the communities most in need. According to HRSA, the primary care residents trained in community-based settings are *three times more likely* than traditionally-trained residents to

practice primary care in a community-based setting. As such, the THCGME Program is *currently* and *directly* addressing our critical primary health care workforce shortage – delivering new primary care physicians to the communities where they are needed most – and should be considered as a model for meeting future health care workforce needs. Unfortunately, the program expires at the end of fiscal year (FY) 2015 and must be reauthorized and funded in order to continue to meet the needs of patients in underserved areas across the country. COGME's recently-released report, "The Role of Graduate Medical Education in the New Health Care Paradigm," offers strong support for continued GME funding for the THCs to ensure that the program is stable, adequate, and assured.

The IOM's report also recognizes the value of the THCGME Program and calls for ongoing funding. However, it specifically calls for the program to be financed under Medicare. AACOM believes that sustained funding via this mechanism is a viable option and would support such a change, either as a mechanism of maintaining this program or as a part of an overall structural change in GME to include sustainable financing.

Medicare GME and Other Proposals

During the discussion of Medicare physician payment reform, AACOM believes it is vital to assess whether there will be sufficient numbers of specialty physicians to meet the health care needs of the growing number of Medicare beneficiaries across the country. Therefore, AACOM strongly believes that any effort to reform Medicare physician payment policy should also increase support for Medicare GME. Ensuring access for Medicare beneficiaries requires long-term and rational physician payment reform, as well as an adequate supply of physicians to care for an aging nation. We respectfully request, in order to help alleviate the current and impending physician workforce shortage and work to ensure provider access to Medicare beneficiaries and all patients, that policymakers incorporate GME expansion provisions introduced in the 113th Congress, such as those included in the *Training Tomorrow's Doctors Today Act* (H.R. 1201), the *Resident Physician Shortage Reduction Act of 2013* (H.R. 1180), the *Resident Physician Shortage Reduction Act of 2013* (S. 577) and *Creating Access to Residency Education Act of 2014* (H.R. 4282), as part of any comprehensive reform legislation.

AACOM believes that GME funding is critical to ensuring the stability and continuity of both the nation's medical residency training programs that produce future physicians and the hospitals that provide care to the nation's citizens. The current number of GME positions funded by CMS will not be sufficient to accommodate the number of medical school graduates seeking positions or the number of positions needed to offset projected physician workforce shortages. Because osteopathic medical students who train in community-based institutions are more likely to practice in these areas, AACOM continues to support GME programs that expand the participation of community-based institutions. This is particularly important at a time when the number of osteopathic medical school graduates is growing and is expected to continue to grow in response to physician workforce shortages that exist and are projected to continue over the next five to 15 years.

Currently, more than 24,000 students are enrolled at osteopathic medical schools, and approximately 25 percent of new U.S. medical students are training to be osteopathic physicians.

According to the AOA, there are nearly 70,000 active osteopathic physicians (D.O.s) practicing in the U.S. today, including those currently in GME programs (or internships, residencies, or fellowships). Of the osteopathic physicians who have completed GME training, 56 percent are practicing in the primary care specialties of family and general practice, pediatrics and adolescent medicine, and general internal medicine. Many current osteopathic medical students will pursue careers in primary care and many will practice in rural and underserved areas; these are the geographical areas that already face shortages of primary care providers. A well-trained physician workforce is essential to ensuring that Americans have access to high-quality health care. This is particularly true of the primary care workforce, for which research has shown that access to primary care lowers costs and improves health outcomes. An adequate number of GME programs is necessary to ensure that the U.S. health care system has a sufficient number of well-trained physicians to provide patients with high-quality health care. This support is critical as we work together to transform the U.S. health care system to one that is more patient-centered, team-based, and prevention-focused.

To further this effort, during the 113th Congress, AACOM endorsed multiple bipartisan non-Medicare solutions to address health care workforce needs, such as the *Building a Health Care Workforce for the Future Act* (H.R. 5458/S. 1152) and *The Foreign Medical School Accountability Fairness Act of 2014* (H.R. 3903/S.1822), which would ensure that uniform standards exist at non-U.S. medical schools receiving Title IV federal financial aid funding.

AACOM also recognizes the tremendous contribution of the IOM's report in offering a paradigm-changing proposal for GME financing, and we support the overarching goals of the report, especially as they relate to reforms to support community-based training; sustainable funding for the THCGME Program; funding for and implementation of national workforce assessment measures to determine health care workforce priorities; increased accountability and transparency measures to better ensure that federal GME funding aligns with patient care; incentivizing initiatives to develop and evaluate innovative GME programs and provide a flexible infrastructure in which this innovation will thrive; expanding GME to community settings, with particular priority given to primary care and rural and underserved areas; and acknowledgment of the importance of expanding incentives for training in needed specialties, such as assistance with debt relief for medical students and graduates in exchange for a long-term commitment to providing primary care.

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

Osteopathic medical education has a long history of establishing educational programs for medical students and residents that target the health care needs of rural and underserved populations. COMs, many of which are located in rural areas, have a standing commitment to and focus on the training of primary care physicians, which mirrors the special commitment osteopathic physicians have to providing high-quality primary care, particularly to the nation's rural and underserved populations. COMs provide clinical training in a variety of community-based locations, in hospitals, and in other health care training facilities. Based on research which indicates that residents who train in community-based institutions are more likely to practice in

these areas, AACOM continues to support GME programs that expand the participation of these institutions.

Supporting non-Medicare programs such as the THCGME Program, which serves as a model of success for delivering GME funding and expanding access to care in the country's most underserved areas, as well as supporting the National Health Service Corps (NHSC), which is in jeopardy and currently faces a fiscal cliff with its funding expiring at the end of FY15, and other loan repayment and scholarship programs, are critical to addressing health care access and delivery to underserved rural and urban communities across the nation. As you are aware, the NHSC provides scholarships and loan repayment options to health care professionals in exchange for practicing primary care in federally-designated health professional shortage areas (HPSAs). The NHSC improves access to health care for the growing numbers of rural and urban underserved Americans, provides incentives for practitioners to enter primary care, and reduces the significant financial burden that the cost of health professions education places on new practitioners.

In addition, AACOM strongly supports the Rural Physician Training Grant Program, included in the President's FY15 budget request, which aims to support rural-focused training programs with the recruitment and graduation of students most likely to practice medicine in underserved rural communities. Health professions workforce shortages are exacerbated in rural areas, where communities struggle to attract and retain well-trained providers. According to HRSA, approximately 65 percent of primary care HPSAs are rural. These programs are critical to addressing physician and health professional shortages in rural and underserved communities. Furthermore, as noted above, and as cited in the IOM report, the location of an individual's medical school and GME training are predictive of practice location, and the longer the period of training in a particular geographic area, the more likely the individual is to practice there. This fact alone necessitates support for rural and underserved urban GME training opportunities.

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

AACOM believes that the current financing structure for GME is not adequate to meet current and future health care workforce needs, and that changes are necessary in order to more closely align training with the physician workforce. With projections of physician workforce shortages already demonstrating a widening gap between the availability of patient care and the health care needs of a growing and aging population, AACOM supports sustainable expansion of GME positions in areas of existing and projected specialty shortages (e.g., primary care, geriatrics, and general surgery) in which there is substantial current demand and anticipated growth in rural and

urban medically-underserved areas (MUAs). In addition, as stated above, we urge support for innovative programs such as the THCGME Program, which increases the primary care workforce while giving residents the opportunity to deliver health care to the country's underserved populations. The current Medicare-GME structure dis-incentivizes primary care funding for training in non-hospital settings, which should instead be supported by revising the financing structure to include incentives that would also support community-based training; the separate payment system for THCGME Program may not be necessary if adequate funding is sustained under a different model (such as that offered by the IOM report) that provides greater transparency and is outcome-based.

AACOM supports the combination of indirect medical education (IME) and direct graduate medical education (DGME) into a PRA as one method to enable financing flexibility, innovation and incentivizing specialty training in areas of need. However, we also recognize that the current system has developed over time to support a medical education infrastructure of great value for the delivery of specialty training and patient care. Therefore, any transition should be implemented in such a manner as to avoid disrupting patient care and the integrity of teaching programs in areas of specialty needs. AACOM also urges caution in modifying the payment system by allowing the PRA to follow residents, a suggestion that has been discussed widely, and ultimately rejected by COGME and other stakeholders. Although such a change would provide greater flexibility for residents, it would potentially erode the financial stability training facilities need to plan, staff, and operate high-quality medical education programs.

AACOM strongly values primary care as the foundation of a modern health care system. Any proposal that would displace physicians from their role in providing high-quality primary care would disrupt the U.S. health care delivery system and create obstacles for the development of a better-integrated system needed to maximize value, access, and quality in patient care. A medical education system that produces the kind of primary care physicians needed to work in a value-driven health care system should be a goal of medical education in general, and of GME in particular. AACOM understands the necessity of evaluating the process of and funding mechanism for future physician training, but we also firmly encourage the Committee to consider the full spectrum of medical education in order to thoroughly understand the complexities of GME as appropriate avenues of reform are explored. Moreover, AACOM believes the OPTI consortia will continue to play an important role in the U.S. health care system by enhancing the quality of osteopathic medical education and the efficiency of training the future physician workforce. Additionally, osteopathic medical schools have fostered innovation in their approach to medical education with a variety of curricular approaches to primary care continuity of training that create medical student-to-resident pathways designed to increase primary care physician output.

1) The Lake Erie College of Osteopathic Medicine's (LECOM) Primary Care Scholars Pathway channels participating osteopathic medical students into residency training at the end of a three-year accelerated D.O. degree program, saving the student one year of tuition payment; this is contingent upon the student's commitment to practice primary care medicine for a minimum of five years after his/her successful completion of residency training.

2) The A.T. Still University of Health Sciences - School of Osteopathic Medicine in

Arizona's (ATSU-SOMA) innovative undergraduate curriculum works in partnership with the National Association of Community Health Centers to place students in MUAs for three years of their undergraduate medical education (see http://macyfoundation.org/docs/macy_pubs/Macy_MedSchoolMission_proceedings_06-09.pdf, 78-80).

Additionally, in partnership with The Wright Center for Graduate Medical Education, ATSU-SOMA has developed an innovative model for GME. Students chosen to participate in this program complete an AOA-accredited three-year family medicine residency program based at one of six community health centers located in a MUA. During this program, residents experience the continuity of primary clinical care training integrated with the completion of a competency-based curriculum (see http://www.thewrightcenter.org/).

While GME is the final stage of physician specialty training before entering independent practice, there is a long pathway leading to the outcomes desired. In addition to the Medicare-GME system, AACOM strongly supports other education and training programs which contribute to the nation's health care workforce, such as the Title VII health professions training programs authorized by the *Public Health Service Act*. These programs support the health professions workforce to improve education and training opportunities in high-need disciplines and settings, and are unique in their focus on training a workforce to address health care disparities and the health care needs of both urban and rural medically-underserved communities. Title VII aims to build a health professions workforce that will meet the nation's urgent health care needs. Programs such as the Primary Care Training and Enhancement, the Centers of Excellence, the Heath Careers Opportunity, the Scholarships for Disadvantaged Students, the Geriatric Educations Centers, and the Area Health Education Centers are vital to health care workforce development and education, especially for providers addressing the needs of underserved populations. These programs have been continually underfunded by Congress and are critical, in addition to GME, in addressing the nation's health care workforce needs.

5. **Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability, and quality?**

As mentioned above, AACOM continues to support accountability and transparency measures such as those included in the *Training Tomorrow's Doctors Today Act* (H.R. 1201) as well as the strict accountability requirements for the THCGME Program, which utilizes every federal dollar exclusively for primary care training. Important legislation such as the *Building a Health Care Workforce for the Future Act* (H.R. 5458/S. 1152) would build upon an innovative and cost-effective solution to sufficiently address the nation's need for a stronger primary care physician workforce. This legislation aims to build a necessary primary care workforce by increasing opportunities for medical schools to support students engaging in initiatives such as those in which primary care physicians take a leadership role in delivery system reform. This legislation will generate expanded access to patient care and is crucial to those in rural and underserved areas, which already face a scarcity of primary care physicians.

AACOM believes that the current GME system dis-incentivizes high-quality training in some disciplines that are community-based, except in such innovative programs as THCs, because they prevent flexibility and innovation designed to provide training in the communities where primary care is delivered, especially in rural areas.

AACOM acknowledges the IOM report's recommendation to establish a new infrastructure to provide oversight, policy direction, and operational expertise to the GME process. This infrastructure would consist of two new entities: a GME Policy Council in the U.S. Department of Health and Human Services' (HHS) Office of the Secretary and a GME Center within CMS. The IOM recommends seeking no new funding to support the new infrastructure. Consequently, AACOM has concerns with funding spent on the Council and Center further reducing aggregate GME funds available for training residents. Furthermore, AACOM would encourage the Committee to explore existing alternative structures to provide the aforementioned oversight, such as allocating responsibilities and additional resources to other federal advisory bodies such as COGME.

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

AACOM strongly believes that any effort to reform Medicare physician payment policy should also increase Medicare support for GME, with a particular emphasis on primary care. According to COGME's recent report, it does not share the IOM Committee's conviction that current funding levels and residency positions are adequate to meet future health needs, and furthermore, "disagrees with the IOM Committee's recommendation that funding should be limited to current levels" and that there exists evidence of shortages in many specialties in areas including family medicine, geriatrics, general internal medicine, general surgery, and pediatric subspecialties.

AACOM urges thoughtful consideration and caution when addressing GME reform, to include ensuring that there are a sufficient number of residency positions, such as primary care and other needed specialty areas, to meet the demands of the nation's patient populations. According to COGME, the nation's workforce should be comprised of at least 40 percent primary care physicians. Expanding GME to community-based settings, with particular priority given to primary care and rural and underserved areas and acknowledgment of the importance of expanding incentives, such as assistance with debt relief for medical students and graduates in exchange for a long-term commitment to primary care are vital in assessing potential changes to the GME system. Moreover, funding for and implementation of a national mechanism to provide workforce assessment measures and appropriate oversight to ensure transparency to determine health care workforce priorities is necessary to support a growing and changing health care system and the physician workforce needed to meet the demand of our nation's health care delivery.

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

AACOM believes that both federal and state governments should play a significant role in the nation's health care workforce. Since the caps put in place by the *Balanced Budget Act of 1997*,

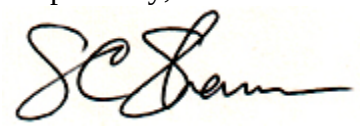
federal GME funding has been unable to meet the demands of the evolving health care system from both workforce and patient population need. Due to many states struggling with budget deficits, they are left with physician workforce and health care delivery deficits, especially in areas of high need. Supporting a sound and sustainable federal GME system which allows for flexibility for innovative models that can include states' roles in supporting GME and community-based training and health care delivery will create better alignment with the nation's evolving health care system.

In addition to the above, AACOM continues to support programs such as the NHSC State Loan Repayment Program, which provides matching funds to states to operate their own loan repayment programs for primary care clinicians working in HPSAs. We believe this program should be expanded to allow for states to have the resources and flexibility needed to address each individual state's workforce needs. AACOM also supports continued and expanded funding for the Title VII health professions programs to support the nation's physician and health professions training pipeline to address state workforce needs. These programs are critical to support national workforce measures at the federal level to provide states with the necessary data and resources in addressing workforce development and patient population needs.

We thank you for your time and consideration, and look forward to the Committee's continued work exploring GME as it relates to producing quality patient care and a robust physician workforce that will meet the demands of our nation's evolving health care system. We are ready to answer questions as well as provide further information and resources the Committee might need as it considers the GME system and the unique and specific role of osteopathic medical education in producing the nation's future physician workforce.

If you have questions or require further information, please contact Pamela Murphy, Vice President of Government Relations, at 301-908-2137 or pmurphy@aacom.org.

Respectfully,



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