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January 16<sup>th</sup>, 2015

The Honorable Fred Upton  
United States House of Representatives  
Chairman, Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Frank Pallone  
United States House of Representatives  
Committee on Energy and Commerce  
2125 Rayburn House Office Building  
Washington, DC 20515

Dear Chairman Upton and Representative Pallone:

On behalf of the over 18,000 orthopaedic surgeon members of the American Association of Orthopaedic Surgeons (AAOS), thank you for giving us the opportunity to respond to your open letter requesting information on graduate medical education (GME). Recognizing the critical nature of several of the challenges faced by GME, the AAOS has hosted symposia and created work groups in order to educate our membership and discuss potential solutions. Additionally, the AAOS Resident Assembly was created this year to further engage and learn from orthopaedic residents in training. Over the past decade, undergraduate medical education has expanded nationwide by more than 30%, greatly outpacing the growth in residency slots. We are now facing a tipping point where some US-trained medical school graduates may not have a first year residency position available to them in the United States. The sustainability of the current GME system is very important to orthopaedic surgeons and we appreciate the opportunity to share our knowledge and input with the committee.

The health and welfare of patients is inextricably linked to the knowledge and skills physicians develop during their clinical training, the major portion of which takes place in the years following graduation from medical school. During this period, which generally lasts three to seven years, young physicians (“residents”) participate in the care of patients and study in supervised educational programs that are based in teaching hospitals. The satisfactory completion of a course of education in one of these approved programs is a pre-requisite to achieving board certification in a chosen medical or surgical specialty. Without residency

training, medical school graduates or “doctors” cannot obtain licenses or practice medicine. Therefore, not having a residency slot available after graduation provides a physician unable to practice their profession with on average more than \$170,000 of debt. This scenario truly leads to a “worst-case” for the graduate, his/her potential patients, and society at large, and must be avoided.

Ensuring that young physicians have the tools necessary to complete a successful residency is beneficial to society as a whole. Therefore, categorizing medical education as a public good is an appropriate designation and the investment from the Medicare system has been the lifeblood of graduate medical education (GME) since 1965. We look forward to ongoing discussions with the committee on this important topic. If we can be of further assistance, please do not hesitate to contact AAOS’ medical director, William Shaffer, MD at [Shaffer@aaos.org](mailto:Shaffer@aaos.org).

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

Graduate medical education is primarily supported through patient care revenues. Traditionally, most payers have implicitly financed graduate medical education because its costs are included in teaching hospital charges. Medicare is the largest single funding source for GME and subsidizes graduate medical education through Medicare reimbursements that factor in the direct (DME) and indirect (IME) costs.

As health care costs have risen, more prudent stewardship of cost have become necessary across the board. The calls to cut costs have made GME funding, especially the IME payments a prime target. Since 1997, the number of federally funded GME spots has been capped to control costs, forcing hospitals and states to find creative ways to fund their needed compliment of residents. In addition, federal policymakers in recent years are currently considering further reductions. As a result of these trends, it is becoming more difficult for teaching hospitals to cover their costs. Reversing the downward trend in medical education funding is necessary to ensure its future stability. In line with the recent Institutes of Medicine report, GME funding at current levels needs to be maintained, while alternative payment models are investigated and piloted, like an all-payer 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 that you support and why?**

AAOS supports several recommendations, below, made in the COGME twenty-second report, "The Role of Graduate Medical Education in the New Health Care Paradigm."

- a) GME training should be expanded in ambulatory and community sites to reflect the current and evolving practice of medicine.
- b) A portion of the financial support for GME training in community and ambulatory settings should be distributed to the educational sites or programs where the training occurs.
- c) There should be greater accountability and transparency for Indirect Medical Expenditures in order to achieve national health care aims and objectives. Reevaluation of the funding process of GME is necessary to ensure equity, proper distribution of specialties, location, and geographical distribution of residents.
- d) GME funding for the Teaching Health Centers (THC) and Children's Hospitals should be stabilized with dedicated ongoing funding
- e) New curriculum is needed to address health care delivery system change and patient and population-centered GME.
- f) There should be a further national effort to coordinate and engage underrepresented minority students in health care professions and medical careers. Public support for GME should be leveraged to encourage physician specialists to locate in otherwise underserved regions and communities.

The AAOS also supported several bipartisan GME expansion bills introduced during the 113<sup>th</sup> Congress (HR 1180/HR 1201/S 577) that would add a total of 15,000 slots to federally designated specialty shortage areas and provide for minimal and appropriate measurement development for teaching programs.

**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?**

The AAOS is committed to access to quality care for all orthopaedic patients. To the extent that training programs provide both educational opportunities to the residents as well as care to the community, we support federal funding in both rural and urban areas. Greater transparency in IME funding

and an updated algorithm for deciding and distributing GME dollars could result in more funds being used to promote training in rural settings.

**4. Is the current financing structure for GME appropriate to meet current and future healthcare needs?**

**i. Should it account for direct and indirect costs as separate payments? If so, are there improvements to current formulas or structure that would increase the availability of training slots and be responsive to current and future workforce needs?**

In providing graduate medical education, teaching hospitals incur a variety of expenses beyond those generated by routine patient care. These include the direct costs of graduate medical education, such as salaries and benefits, including the cost of medical malpractice insurance, for residents, faculty and other support staff and the costs of institutional space devoted to clinical training and research. They also include the indirect costs of graduate medical education, which reflect the additional staff time and other hospital resources needed to involve residents in patient care. It is critical to show that funds paid towards indirect costs of graduate medical education are appropriately disbursed and the AAOS calls for greater transparency of these funds. Most importantly, it is in the best interest for all stakeholders that there is no decrease in the amount of money Medicare spends on GME.

**ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?**

The AAOS believes the financing of graduate medical education should not be used as a means to implement national physician workforce policies. It would be difficult for any federally funded program to usurp the other factors medical students take into considerations when choosing a medical residency, such as quality of life or personal fulfillment. The AAOS recommends that physician workforce policies be developed through a careful and deliberative process that takes into account all of the factors that influence how physicians choose their specialties. Furthermore, policies on physician workforce should be designed in ways that do not threaten the quality of graduate medical education in those specialties that are not currently experiencing workforce shortages.

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

The AAOS believes that the United States teaching hospital systems provide a model for physician training around the world. Some proposals surrounding GME reform call for increased accountability measures that would eventually be tied to funding. However, the AAOS believes there are sufficient programs that help keep all hospitals and health centers accountable for the services they provide and that it would be inappropriate to impose potential additional financial burdens on these programs.

**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 solve these problems?**

The AAOS believes the current system of residency slots is appropriately meeting the nation's present healthcare needs, particularly in orthopaedics. However, there are several factors contributing to a surgical workforce shortage to consider. Increased insurance coverage, the growing population overall, the aging population, the aging physician population and the medical advances increasing utilization may all lead to an expected decline in physicians per capita. Additionally, it currently takes between eight and 10 years before a medical student becomes a practicing physician. Therefore, we suggest periodic surveys of the need for specialists, including orthopaedic surgeons, should be completed to allow for optimal planning. We do not believe funding for such a survey should come out of current GME funds.

Additionally, AAOS firmly believes that all residency slots across medical and dental professions should be treated with equity. The Balanced Budget Act of 1997 limited the number of allopathic and osteopathic medical residents that would be counted for purposes of calculating Medicare indirect medical education (IME) and direct graduate medical education (DGME) reimbursement. However, podiatry residents are excluded from this resident limit. The AAOS believes that in order to eliminate preferential funding, podiatry training programs should adhere to a limited number of positions as well. The unlimited number of funded podiatry training positions serves as an advantage to podiatrists, who are more limited than orthopaedic surgeons in the type of musculoskeletal services they can provide. These asymmetric

limits affect the available training pipelines and have very real workforce implications.

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

The AAOS firmly believes that there is a strong role for states to play in defining our nation's current healthcare workforce and we acknowledge that many states have worked to address the problem. Almost half of residents who train in a state end up practicing in the same state. Most states are assessing and coming up with innovative ways to fund GME in recognition that it is an investment in the state's long-term physician workforce. In one example, the Texas state legislature recently directed an assessment to be conducted by the Texas Higher Education Coordinating Board to evaluate the adequacy of opportunities for graduates of Texas medical schools to enter graduate medical education in the state. Since 1997, Utah has had a CMS waiver that allows them to pool GME funding into the Utah Medical Education Council. The state then performs ongoing state workforce analysis and distributes GME funds according to those needs. The federal government should continue to support GME through Medicare while encouraging states' attempt/initiatives to address this critical issue in a tailored way that best fits their unique needs.

The AAOS appreciates the ongoing support of the Medicare systems for graduate medical education. Our hope is that through our collective investment in today's residents, we will reap the benefits of an entire generation of physicians who care for their patients and carry this noble profession forward. Please let us know what else we can do to contribute to your ongoing efforts to address this complicated and important topic.

Sincerely,

A handwritten signature in black ink that reads "Frederick M. Azar". The signature is fluid and cursive, with a checkmark-like flourish at the end.

Frederick M. Azar, MD  
President  
American Association of Orthopaedic Surgeons