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Darrell G. Kirch, M.D.
President and Chief Executive Officer

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The Honorable John Tester
United State Senate
311 Hart Senate Office Building
Washington, DC 20510

Dear Senator Tester:

Thank you for your leadership in helping ensure that our nation's veterans have access to physicians. The Association of American Medical Colleges (AAMC) is pleased to endorse the expansion of Medicare funding for Graduate Medical Education (GME) under the "Delivering Opportunities for Care and Services (DOCS) for Veterans Act" (S. 1676).

The AAMC is a not-for-profit association representing all 144 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs (VA) medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

VA physician shortages are symptomatic of a broader trend, the proverbial "canary in the coal mine." The AAMC projects a nationwide shortage of between 46,000-90,000 physicians by 2025. Though these shortfalls will affect all Americans, the most vulnerable populations in underserved areas will be the first to feel the impact (e.g., the VA, Medicare and Medicaid patients, rural and urban community health centers, and the Indian Health Service).

To address this shortage, the nation's medical schools have done their part by expanding enrollment by 30 percent. However, there has not been a commensurate increase in the number of GME residency training positions. The primary barrier to increasing residency training at teaching hospitals — and the U.S. physician workforce in turn — is the cap on Medicare GME financial support, which was established in 1997. Thankfully, the DOCS for Veterans Act helps address this hurdle.

Just as Medicare GME supports Medicare's share of training costs at institutions that care for Medicare beneficiaries, VA GME supports residency training programs based at VA medical centers. The Veterans Access, Choice, and Accountability Act of 2014 instructs VA to add 1,500 GME residency slots over five years at VA facilities that are experiencing shortages. However, without an increase in Medicare GME support, there may not be enough affiliate residency positions to accommodate this VA expansion.

Most VA residency programs do not operate independently. They rely upon the existing administrative and training infrastructure maintained by the nation's medical schools and teaching hospitals. Nearly all VA residency programs are sponsored by an affiliate medical school or teaching hospital. Currently, 127 VA facilities have affiliation agreements for physician training with 130 of the 144 U.S. medical schools.

To assure that VA-based residents receive the highest quality training possible, they need diverse and supervised experiences in a variety of clinical settings. This includes training experiences at the nation's teaching hospitals and the multispecialty practices run by the nation's medical schools. While there is considerable variability among VA medical centers, programs, and specialties, on average medical residents rotating through the VA spend approximately three months of a residency year at the VA (i.e., a quarter of their training).

As such, simply increasing VA GME funding alone will not address the VA crisis. Without a corresponding increase in Medicare GME support, VA medical centers will be unable to capitalize fully on increases in VA GME funding. The DOCS for Veterans Act will allow affiliate teaching hospitals that are already at or above their 1997 Medicare GME cap to receive Medicare support for VACAA residents while they are training at a non-VA facility. This will allow the VA and its academic affiliates to build on an already successful 70-year partnership.

Thank you again for you leadership on this important matter. I look forward to working with you to improve care for our nation's veterans and on legislation to help address nationwide physician workforce shortages.

Sincerely,

Darrell G. Kirch

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Physician Supply and Demand Through 2025: Key Findings

In March 2015, the economic modeling and forecasting firm IHS Inc. released a new study, *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*, at the request of the AAMC. Projections for individual specialties were aggregated into four broad categories for reporting: primary care, medical specialties, surgical specialties, and "other" specialties.[1] To reflect future uncertainties in health policy and care use and delivery patterns, the study presents ranges for the projected shortage of physicians rather than a specific shortage number.

Demand for physicians continues to grow faster than supply. Although physician supply is projected to increase modestly between 2013 and 2025, demand will grow more steeply.

- **Total physician demand is projected to grow by up to 17 percent,** with population aging/growth accounting for the majority. Full implementation of the Affordable Care Act accounts for about 2 percent of the projected growth in demand.
- **By 2025, demand for physicians will exceed supply by a range of 46,000 to 90,000**. The lower range of estimates would represent more aggressive changes secondary to the rapid growth in non-physician clinicians and widespread adoption of new payment and delivery models such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs).
- **Total shortages in 2025** vary by specialty grouping and include:
  - A shortfall of between **12,500 and 31,100 primary care physicians.**
  - A shortfall of between **28,200 and 63,700 non-primary care physicians,** including:
    - 5,100 to 12,300 medical specialists
    - 23,100 to 31,600 surgical specialists
    - 2,400 to 20,200 other specialists[2]

The physician shortage will persist under every likely scenario, including increased use of advanced practice nurses (APRNs); greater use of alternate settings such as retail clinics; delayed physician retirement; rapid changes in payment and delivery (e.g., ACOs, bundled payments); and other modeled scenarios.

Addressing the shortage will require a multi-pronged approach, including innovation in delivery; greater use of technology; improved, efficient use of all health professionals on the care team; and an increase in federal support for residency training. The study's results confirm that no single solution will be sufficient on its own to resolve physician shortages.

Because physician training can take up to a decade, a physician shortage in 2025 is a problem that needs to be addressed in 2015.

1 **Primary care** consists of general & family practice, general internal medicine, general pediatrics, and geriatric medicine. **Medical specialties** consist of allergy & immunology, cardiology, critical care, dermatology, endocrinology, gastroenterology, hematology & oncology, infectious diseases, neonatal-perinatal medicine, nephrology, pulmonology, and rheumatology. **Surgical specialties** consist of general surgery, colorectal surgery, neurological surgery, obstetrics & gynecology, ophthalmology, orthopedic surgery, otolaryngology, plastic surgery, thoracic surgery, urology, and vascular surgery. The **other specialties** category consists of anesthesiology, emergency medicine, neurology, pathology, physical medicine & rehabilitation, psychiatry, radiology, and all other specialties.

2 The shortage range for total physicians is smaller than the sum of the ranges for the specialty categories. The demand scenarios modeled project future demand for physician services, but scenarios can differ in terms of whether future demand will be provided by primary care or non-primary care physicians. Likewise, the range for total non-primary care is smaller than the sum of the ranges for the specialty categories.