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Medicare Payment Advisory Commission (MedPAC)
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth and MedPAC Commissioners:

On behalf of the Association of American Medical Colleges (AAMC), which represents nearly 300 nonfederal major teaching hospitals and the nation's 126 allopathic medical schools and related clinical physician faculty, I write to urge you to withdraw the draft recommendation to cut the indirect medical education (IME) adjustment by one percentage point that was presented at the Commission's December meeting. We also support the views of the American Hospital Association and urge the Commission to recommend a full market basket update for federal fiscal year (FY) 2009 payments for inpatient and outpatient services.

December's draft IME recommendation essentially repeats a recommendation approved last year by the Commission. Such a recommendation, if implemented, would represent an 18 percent cut in all IME payments to teaching hospitals, totaling **900 million dollars** annually. In a letter we provided to the Commission last year, the Association set forth the reasons we believe such a cut is unwarranted.

The IME payment adjustment cannot be viewed solely in the context of Medicare regression analyses. As history has demonstrated, the purpose and value of IME payments are integral to supporting the overall missions of teaching hospitals. These include serving as sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; being sources of specialized, unique, and referral/standby services; and serving as safety net providers for the poor and uninsured. Because of their education and research missions, teaching hospitals offer the newest and most advanced services and equipment, and often care for the nation's sickest and most complex patients. Today, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical or nuclear attack, or natural disaster, and they are devoting resources to fulfill those expectations.

In addition to our overarching view that the current level of the IME payment adjustment should be maintained, we also feel strongly that this year is a particularly detrimental time to consider cutting Medicare IME payments to teaching hospitals. As discussed

below, these institutions are facing the possible elimination of Medicaid graduate medical education (GME) payments. This represents a potential estimated loss of nearly one billion dollars annually. CMS also has issued an interim final rule to eliminate an estimated \$374 million dollars in Medicare capital IME payments. If not reversed, we fear these scheduled reductions will severely restrict the financial resources available to teaching hospitals, jeopardizing their vital patient care, educational and research missions.

MEDICAID SUPPORT FOR TEACHING HOSPITALS

In May 2007, CMS issued a proposed rule to eliminate federal matching funds for Medicaid GME payments (72 Fed. Reg. 28930 (May 23, 2007)). CMS estimates this rule will reduce Federal outlays by cutting nearly two billion dollars in federal Medicaid payments to teaching hospitals over five years (72 Fed. Reg. at 28934). While no precise estimates of Medicaid GME funding exist, we believe CMS likely underestimates the financial impact, given their inability to quantify these payments as well as their assumption that states will redirect their GME funding to other hospital payments that can qualify for the federal match.

The AAMC was surprised and greatly disappointed by CMS's decision to pursue the elimination of Medicaid GME payments given the vital role of teaching hospitals in caring for Medicaid patients and training the physicians that serve this vulnerable population. Moreover, this rule would undo a long-standing history of support for such payments that has extended for decades. The Association submitted comments urging the Agency to rescind the proposed rule.¹ Last May, Congress issued a one-year moratorium preventing CMS from taking any action to finalize the rule.² If this rule is finalized, we believe the cuts will not only erode critical financial resources that support GME programs, but they will likely affect other services offered to Medicaid, Medicare and other patients by reducing teaching hospitals' total financial resources. Such a result is not in the best interests of the nation's health care system.

OTHER MEDICARE POLICIES AFFECTING SUPPORT FOR TEACHING HOSPITALS

Currently, there are a number of Medicare policies that are eroding Medicare's support for teaching hospitals on an ongoing basis. Primary among these was the imposition of resident caps. However, other regulatory actions are similarly reducing IME and DGME payments to teaching hospitals.

¹ See the AAMC letter at <http://www.aamc.org/advocacy/library/teachhosp/corres/2007/062207.pdf>

² Section 7002(a) of the Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 (Pub. Law 110-28) prohibits, for one year, the promulgation or implementation of "any rule or provisions" restricting Medicaid payments for graduate medical education (GME).

Resident Caps

In addition to initiating a multi-year 28 percent across-the-board reduction in the IME adjustment (from 7.7 percent to 5.5 percent), the Balanced Budget Act of 1997 (BBA) implemented a hospital-specific resident “cap” that eliminates Medicare IME and DGME payments associated with residents above each hospital’s 1996 count of resident full time equivalents (FTEs).

The academic medicine community understood at the time the BBA was passed that Congress was establishing a cap on the number of physician residents that would be countable for Medicare DGME and IME purposes for two reasons. One reason was so the teaching hospital community, along with many others, could contribute toward achieving a balanced Federal budget. Another reason was to address the concerns of workforce experts in the early to mid-1990s of an impending oversupply of physicians. This conventional wisdom was predicated in large part on reports published in the early 1990s by the Federal Council on Graduate Medical Education (COGME), a body that advises Congress and the U.S. Department of Health and Human Services on GME and the physician workforce.⁴ Independent research conducted by health economists and policy experts, including the Institute of Medicine, generally supported these findings. Thus, when adopting the resident cap provision in the BBA, Congress sought to significantly limit the production of physicians in response to the belief at the time that indicated a looming physician oversupply.

Currently the vast majority of health policy analysts and physician workforce researchers agree that these earlier studies were in error and that the country now faces a potentially severe physician shortage. The Health Resources and Services Administration’s (HRSA) Bureau of Health Professions projects a national shortage of at least 55,000 physicians by the year 2020; many states and physician specialties already are experiencing shortages.

This has enormous implications for health care in this country. Considering the amount of time it takes to educate and train a physician--four years of medical school, plus a minimum of three years of residency training--teaching hospitals and medical schools must act rapidly to avert a future shortage. A 2005 COGME report, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, recommends an increase in medical school enrollment along with the cap on Medicare-supported resident positions. In 2006, the AAMC adopted a similar position.

Because of physician workforce needs and their commitment to their educational missions, a number of teaching hospitals have increased the number of residents they train beyond their 1996 caps. Consequently, as of 2005, almost one-half of all teaching hospitals had IME resident counts exceeding their caps by an aggregate of 5,582 and

⁴ See, in particular, *Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century* (COGME Third Report, October 1992) and *Recommendations to Improve Access to Health Care Through Physician Workforce Reform* (COGME Fourth Report, January 1994).

DGME counts that exceeded their caps by an aggregate of 4,711³ **These hospitals receive no Medicare IME or DGME support associated with these additional residents.** It is clear that the Medicare resident caps must be lifted to provide some financial support for those teaching hospitals that are trying to respond to the needs of their communities and the nation as a whole.

Capital IME Payments

In the FY 2008 Medicare inpatient PPS final rule (72 Fed. Reg. 47130 (August 22, 2007)) CMS implemented an “interim final rule with comment” to eliminate the capital IME adjustment beginning in FY 2009. According to the rule, the IME adjustment will be reduced by 50 percent in FY 2009 and eliminated altogether in FY 2010 and beyond. Unless rescinded, this regulation will cut aggregate payments to teaching hospitals by \$375 million annually.

Recent Medicare Regulations Are Reducing Resident FTE Counts Eligible for DGME and IME Payments

Recent regulatory interpretations of the Medicare IME and DGME statutes are further reducing Medicare support for the special missions of teaching hospitals by limiting hospitals’ resident FTE counts that are included in the calculations of IME and DGME funding. The Agency’s questionable and narrow interpretations of DGME and IME policies have resulted in teaching hospitals and their academic leaders often being forced to choose between retaining critical DGME and IME funding or assuring that residents experience training in ambulatory sites (as urged by Congress and others), are exposed to clinical research activities, and keep up with the latest developments in scientific and quality initiatives.

For example, under the FY 2007 Medicare inpatient PPS final rule, CMS stated that teaching hospitals may not include in their IME resident count any time that a resident spends in grand rounds, conferences, or other “didactic” activities, regardless of whether these activities occur in the hospital or in a nonhospital setting.⁴

We strenuously disagree with the CMS position. However, until the policy is changed, the financial impact is a *de facto* cut in IME payments because no resident can be counted as a full FTE for IME payment purposes since all residents must spend at least part of their training time in didactic activities. From an educational perspective, CMS’s policy sends a message to the academic medical community that the Medicare program does not value the full range of education activities that are necessary to train a physician.⁵

³ AAMC Analysis of Medicare cost reports, October 16, 2007 Release. The numbers differ for DGME and IME because the rules for counting residents differ somewhat for DGME versus IME payments.

⁴ For DGME payments, only didactic activity that occurs within the hospital complex is countable.

⁵ To learn more about this policy and our position, you may access our inpatient comment letter at <http://www.aamc.org/advocacy/library/teachhosp/corres/2006/061206c.pdf>

MEDICARE OUTPATIENT PPS

It also is important to recognize that the Medicare outpatient PPS system does not include any type of IME adjustment, despite the negative Medicare outpatient margins of major teaching hospitals. Major teaching hospitals' outpatient margins are significantly lower than those of other hospital groups,⁶ indicating that the outpatient PPS may not appropriately reflect the services provided, and patients treated, in teaching hospitals' emergency rooms and outpatient clinics. We believe an adjustment is warranted. We urge MedPAC to conduct an analysis of the outpatient PPS to provide an independent assessment as to why major teaching hospitals have significantly lower outpatient PPS margins than other hospitals and to determine whether, and to what extent, an IME adjustment should be added to this payment system.

CONCLUSION

Teaching hospitals provide important societal missions on margins that are consistently lower than those of most other hospitals. Despite this, these institutions continue to aggressively pursue innovations related to all aspects of their patient care, education, and research missions--from providing high quality patient care to training future physicians who are prepared for the challenges presented by an increasingly diverse and complex health care system. While much activity has been undertaken, the academic medical community believes that more can and must be done. However, making these important changes while simultaneously fulfilling ongoing responsibilities requires a stable and adequate financial base of support. Within this important context, the government should not implement a nearly 20 percent reduction in IME payments. We urge the Commission not to proceed with the draft recommendation.

On behalf of the AAMC, thank you for this opportunity to share some of our views with you.

Sincerely yours,



Robert M. Dickler
Senior Vice President
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cc: Mark Miller, Ph.D, MedPAC Executive Director
Karen Fisher, AAMC

⁶ In 2005, major teaching hospitals had a -19.1 percent aggregate Medicare outpatient margin, compared to -6.9 percent for other teaching hospitals, and -8.0 percent for non-teaching hospitals.