



May 28, 2009

**Comments of
The Association of American Medical Colleges (AAMC)
to the
Senate Finance Committee**

**“Financing Comprehensive Health Care Reform:
Proposed Health System Savings and Revenue Options”**

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Introduction

The Association of American Medical Colleges (AAMC) thanks the Senate Finance Committee (SFC) for the opportunity to comment on its May 20, 2009 description of policy options, “**Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options.**”

The AAMC is a not-for-profit association representing all 130 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 125,000 faculty members, 75,000 medical students, and 106,000 resident physicians. The AAMC and its members are committed to improving the nation's health through medical education, research, and high-quality patient care. Together, our members provide approximately one-fifth of all clinical care in the country and over forty percent of hospital charity care.

The nation's teaching hospitals and medical schools continue to appreciate the transparent process being used by the SFC to help facilitate public comments on its policy options for health care reform. As we have noted in previous comment letters, we are pleased that the SFC's health reform objectives align closely with those of the AAMC.

The AAMC agrees that controlling rising health care costs is one of our nation's greatest challenges (particularly as our population ages, and as we work to improve health care access for all Americans). The AAMC is committed to helping the SFC tackle that challenge. However, it is important that any reduction in health care expenditures not result in unintended consequences that could prove problematic in the long-term. We are

particularly concerned by the Committee's policy options of reducing federal support for Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) payments. As discussed below, these payments help support the missions of teaching hospitals, including care for the underserved and creating an optimal environment for the training of health professionals. These missions are critical to the sustained success of any health care reform initiatives.

In that context, the AAMC strongly urges the SFC to incorporate the following comments as it moves forward in drafting specific policy proposals to help finance an improved health care system that meets the nation's growing and changing needs. Our comments reflect perspectives from our broad membership of physicians, hospitals, medical researchers, and the educators of the next generation of health professionals. We look forward to working with the SFC and other policymakers to ensure the best policies to achieve better health for the nation are enacted.

Updating Payment Rates for Inpatient Services

The options paper asks for input on Medicare and Medicaid payments for Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME), as well as Medicare and Medicaid DSH payments. At the outset, it is important to recognize that these payments are critical to the financial viability of teaching hospitals and other safety net institutions. Teaching hospitals (and the clinical medical school faculty they collaborate with) are eager to help lead changes to the nation's delivery system. However, as they pursue such changes, it is important that we not destabilize the financial health of teaching hospitals (and jeopardize access to necessary care in both the short- and long-term) through efforts to achieve savings.

Implementing new programs and structures will take time. Consequently, we believe that current programs should be fully supported until we are sure their replacements are, as determined by a variety of criteria, better and more rational than the systems they would be replacing.

The Unique Roles of Teaching Hospitals

The AAMC's teaching hospital members, also known as the Council of Teaching Hospitals and Health Systems (COTH), account for just six percent of all hospitals yet provide a disproportionately large amount of care to Medicaid and uninsured patients, including 41 percent of hospital charity care and 28 percent of all Medicaid inpatient care. These six percent of hospitals also provide nearly one-fifth of all Medicare discharges. Moreover, many of these Medicare patients are sicker and have more complicated illnesses. The average Medicare case mix index for AAMC COTH hospitals is 1.7, *versus* 1.5 for other teaching hospitals and 1.3 for non-teaching.

Teaching hospitals have a unique role in our nation's health care system. In addition to providing safety-net care and basic health services to their communities (e.g., primary and secondary care), teaching hospitals also are responsible for the education and training

of all types of health care professionals; for providing an environment in which clinical research can flourish; and for providing highly specialized tertiary patient care such as burn care, trauma and cardiac care, and transplant services. Because of their education and research missions, teaching hospitals offer the most advanced, state-of-the-art professional expertise, patient services and clinical technology. Staffed with residents and supervising physicians specializing in multiple areas, teaching hospitals care for the sickest patients in communities. Many teaching hospitals also serve as regional referral and educational centers for community hospitals and other community-based providers.

Medicare Support for Graduate Medical Education

The distinctive capabilities, capacities, and responsibilities of teaching hospitals do not come without a price. For decades, the Medicare and Medicaid programs have helped to offset some of these additional costs. DGME payments help fund the some of the direct costs associated with training resident physicians. IME payments offset a portion of the higher patient care costs incurred by teaching hospitals as a result of the complex patient population they treat, along with and their role in creating uniquely dynamic environments for clinical training. Because they have such distinct purposes, we believe it is important to separately discuss DGME and IME payment policies.

Additionally, as indicated later in this document, we strongly urge the SFC to consider GME and DSH payments separately, as they serve very different purposes.

Medicare DGME Payments

The purpose of DGME payments is to compensate teaching hospitals for Medicare's share of the costs directly related to the graduate training of physicians ("residency training"). These costs include the stipends and fringe benefits of residents, salaries and fringe benefits of faculty who supervise the residents, and other direct costs, such as those associated with ensuring proper administrative oversight of all GME programs. Medicare only pays its "share" of these costs, based on a teaching hospital's ratio of Medicare inpatient days to total days.

The Balanced Budget Act of 1997 (BBA) "capped" Medicare DGME payments by placing a limit on the number of full-time equivalent (FTE) residents in allopathic and osteopathic training programs that a hospital can count for purposes of receiving DGME payments. In general, Medicare will not provide support for FTE resident counts that exceed the number of residents reported on a teaching hospital's most recent Medicare cost report for the year ending on or before December 31, 1996. This cap, in place for over a decade, has greatly impeded the ability of teaching hospitals to train a well-skilled health workforce adequate to meet the nation's needs. This is especially important as the nation discusses reforms to the health care system, since the "need for more doctors comes up at almost every Congressional hearing and White House forum on health care...Lawmakers from both parties say the shortage of health care professionals is already having serious consequences" (R Pear, New York Times, April 26, 2009; p. A-1).

Medicare IME Payments

In recognition of the fact that the additional missions of teaching hospitals increase the operating costs of patient care and that differences exist in operating costs between teaching and non-teaching hospitals, the Medicare program includes IME payment adjustments in its prospective payment system (PPS) for added operating and capital expenses. Unfortunately, the IME adjustment is mislabeled as an “educational” payment and is frequently misunderstood. While its label has led many to believe this adjustment to the diagnosis-related group (DRG) payments compensates teaching hospitals solely for the indirect costs associated with graduate medical education, its purpose is much broader. Both the House Ways and Means Committee and the Senate Finance Committee clearly identified the adjustment as having a patient-care rationale :

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents....The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.

(House Ways and Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report, No. 98-23, March 11, 1983).

Specifically, teaching hospitals receive an IME payment for every Medicare patient they treat. The IME adjustment is a percentage add-on to the basic DRG amount. A hospital's IME payment reflects its individual intern/resident-to-bed (IRB) ratio and a nationwide adjustment factor. The adjustment factor is established (and has been changed periodically) by Congress. It is important to note that this ratio serves only as a *proxy* for the increased costs and value of teaching hospitals to communities.

The BBA of 1997 included a schedule for reducing IME payments by 28.75 percent over a four-year period, from 7.7 to 5.5 percent. The schedule was altered by the Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113), the Beneficiary Improvement and Protection Act (BIPA) of 2000 (P.L. 106-554), and most recently, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173). The BBA reduced the IME percentage add-on from 7.7 percent in FY 1997 to 7.0 percent in FY 1998 and 6.5 percent in FY 1999. The BBRA and BIPA maintained the IME adjustment at 6.5 percent in FYs 2000, 2001 and 2002 before reducing it to 5.5 percent in FY 2003 and thereafter. The MMA increased the IME adjustment from 5.5 to 6.0 percent on April 1, 2004; to 5.8 percent in FY 2005; and to 5.55 percent in FY 2006. In FY 2007, IME payments were reduced to 5.35 percent before being set at 5.5 percent in FY 2008 and beyond.

Similar to DGME payments, the BBA also placed a cap on the number of residents that can be included in the numerator of the IRB ratio, based on the count that was reported in 1996.

Policy Recommendations for Medicare DGME and IME Payments

To sustain the nation's teaching hospitals and the unique training environments and patient services they provide, the AAMC urges the following steps be taken:

- ***Lift the Medicare Resident Caps***—The Medicare resident caps have been in place for more than 10 years while the nation is facing a physician shortage of over 100,000 physicians in multiple specialties. The caps have severely restricted the ability of teaching hospitals and medical schools to increase the nation's physician workforce and meet the needs of local communities.

The AAMC strongly urges the SFC to include in any health reform legislation the language included in the AAMC-supported “Resident Physician Shortage Reduction Act” (S. 973/H.R. 2251). Introduced by Sens. Nelson (D-FL), Schumer (D-NY), and Majority Leader Reid (D-NV), the bill makes a more comprehensive and significant investment in physician training by adding 15 percent more Medicare-funded GME positions. Since 1997, when the BBA caps were implemented, Medicare has been severely restricted in the level of support it can provide for physician training and the unique clinical training environment maintained by teaching hospitals. This, in no small part, has contributed to physician shortages across the nation, particularly in primary care.

- ***Preserve DGME and IME Payment Levels***—Given these times of increasing financial uncertainty for teaching hospitals, it is important that the Medicare program maintain its commitment made in 1965 to support the additional costs associated with the educational, research, and patient care missions of teaching hospitals.

As mentioned above, the IME adjustment has been cut by nearly 30 percent since 1997. It is important that this vital Medicare payment adjustment not 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 payments help to support the clinical environments where the education of future physicians occurs, research is translated from the bench to bedside, and trauma and other complex care is provided. The high value environment has enabled teaching hospitals to provide services unavailable elsewhere in the community, lead on new treatments for disease, HIT, quality and safety, and training of virtually all health professionals together.

Congress acknowledged the importance of Medicare's support for teaching hospital missions most recently in May 2009. 220 members of the US House of Representatives and 56 US Senators signed bipartisan letters urging the Obama Administration to rescind a rule eliminating Medicare's capital IME adjustment—approximately \$360 million a

year. Clearly such Congressional concerns for teaching hospital missions are in stark contrast to the cuts recommended by MedPAC.

Medicaid Support for the Special Missions of Teaching Hospitals

According to a 2006 AAMC survey, Medicaid programs in 47 states and the District of Columbia make special payments to teaching hospitals to help offset the costs associated with GME. The survey found that combined state and federal Medicaid support for graduate medical education (DGME and IME collectively) totals an estimated \$3.2 billion annually.

The AAMC has historically opposed any effort to reduce and/or eliminate critical federal Medicaid support for teaching hospitals and GME. Most recently, the AAMC has strongly urged the rescission of the May 2007 CMS proposed rule “clarifying” that state GME payments are not eligible for a federal Medicaid match. If finalized, the rule will represent a major reversal in long-standing federal Medicaid policy, and will erode the ability of teaching hospitals to maintain services that benefit all patients, including Medicaid beneficiaries.

Thanks to the efforts of Congress, a moratorium prevented until April 30, 2009 any efforts to finalize the rule. We strongly urge Congress to work to prevent implementation of the Medicaid GME proposed rule.

Medicare and Medicaid DSH Payments

DSH payments help offset costs incurred by hospitals that treat disproportionately high numbers of underinsured and uninsured patients. Because of the special missions of teaching hospitals and physicians, many serve a disproportionate share of low-income individuals and thus receive DSH payments from both the Medicare and Medicaid programs.

While the AAMC recognizes and supports the need to change the structure of our health care financing and delivery system, we also recognize that implementing alternatives and improvements will take time. Consequently, we believe that the current Medicare and Medicaid DSH programs should be fully supported until we are certain that the replacements (as determined by a variety of criteria) better address the needs of underinsured and uninsured Americans. New plans should not be financed by prematurely reducing or eliminating current DSH programs. Hospitals treat vulnerable populations in myriad ways and require flexibility to meet the specific needs of the populations they treat. We must avoid the lure of terminating existing programs before new ones are proven and established. Not doing so would jeopardize the care provided to millions of vulnerable patients.

Other Health Care Related Revenue Raisers

Modification of FICA Tax Exception for Students

The AAMC strongly opposes codifying the IRS regulations on the student exception. The regulations were developed after a long and intensive period, during which stakeholders met with the IRS and submitted comments on the proposed rule. The AAMC is aware that the rule has been successfully challenged in several court cases currently under appeal. Once the legal process has been exhausted, there may be a reason to consider whether legislation is appropriate. At the current time, however, the regulation is fully implemented and affected entities and individuals are in compliance; there is no need for legislation.

Modification of the Requirements for Tax-Exempt Hospitals

The AAMC strongly opposes codifying organizational and operational requirements for determining whether a hospital is a charitable organization for purposes of section 501(c)(3) tax-exempt status.

The IRS has just modified Form 990, and for the 2008 tax reporting year has added Schedule H to allow hospitals to report on charity care and other community benefit activities. However, it will not be until the 2009 tax-reporting year that hospitals are required to file a complete Schedule H. Due to the lack of a reporting requirement in previous years, there is currently no consistent information to compare hospitals' charity care and community benefit activities, and to consider whether the amount being provided is appropriate. It is premature to legislate this type of requirement. The AAMC cautions that the amount of charity care and other community benefits provided should be based on an assessment of a community's needs. A requirement that every hospital that merits a 501(c)(3) status should provide the same amount of charity care would be unworkable and likely result in the unfair treatment of certain hospitals.

The AAMC believes that tax laws should not be used to force hospitals to provide free care. This would unfairly burden hospitals and flies in the face of efforts to provide individuals with the health care they need on an outpatient basis as a way to prevent hospitalizations and improve the quality of care. Under EMTALA, Medicare-participating hospitals that offer emergency services must provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC) and must provide stabilizing treatment for patients with EMCs. If individuals are unable to pay for care beyond what EMTALA requires, then health care reform should find a mechanism to make it available to them while paying providers adequately for their services.

Over the past few years hospitals have reformed their billing and collection policies and practices, so it is unclear as to why legislation is needed.

The AAMC appreciates the commitment of the SFC to improving health and health care and appreciates the opportunity to share these comments as the nation works towards thoughtful, effective policies that minimize unintended consequences. While we recognize the difficulties in developing new financing policies that will help tackle critical issues regarding health care and the fiscal security of our nation, we urge the SFC to refrain from considering cuts that will de-stabilize teaching hospitals and medical schools in a way that could jeopardize their ability to care to the communities they serve. We look forward to working with you to ensure that meaningful health care legislation is enacted this year.

A handwritten signature in black ink, appearing to read 'Atul Grover', with a stylized flourish extending from the bottom.

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