



**Association of
American Medical Colleges**
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October 27, 2009

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

Dear Majority Leader Reid:

On behalf of the Association of American Medical Colleges (AAMC), I applaud the significant progress you and your colleagues have made toward achieving comprehensive health care reform this year. The AAMC and our members share your commitment to implementing reforms that will improve health care access, quality and affordability for all Americans. We stand ready to work with you in support of solutions that strengthen the health of our nation.

As you continue your work toward finalizing a Senate agreement on health care reform legislation, the AAMC wishes to reiterate the following positions on issues of greatest interest to the nation's medical schools and teaching hospitals. Where possible, we have referred to specific provisions within the "America's Healthy Future Act," as adopted by the Senate Finance Committee.

Background

The AAMC is a not-for-profit association representing the nation's 131 medical schools, nearly 400 major teaching hospitals and health systems 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.

Together, our members provide approximately one-fifth of all clinical care in the country. They also train future physicians and provide clinical sites for the education of other health professionals. The AAMC membership cares for a disproportionately large number of uninsured individuals, as well as people in need of specialized services unavailable elsewhere in their communities. Major teaching hospitals (in collaboration with various clinical providers, including medical school faculty) account for 6 percent of all acute care hospitals, yet provide 40 percent of all hospital charity care and 26 percent of Medicaid inpatient care.

Additionally, the National Institutes of Health (NIH) recognizes the AAMC membership's unique capacity and commitment to advancing scientific knowledge by investing nearly one-half of its annual extramural budget in support of research conducted at medical schools and teaching hospitals.

Physician Workforce

The nation will have a shortage of 125,000 physicians by the year 2025, and many communities are already finding it difficult to access medical services. Efforts to expand health care access will only exacerbate that shortage. The physician workforce must grow to reflect our population and its evolving health care needs, particularly as the number of people over the age of 65 expands. Because the education and training of a physician may require a decade or more, the nation must start investing *today* in the growth of the physician workforce. Without an immediate and significant expansion of the physician workforce, access problems for all individuals will be exacerbated. We strongly support the language of S. 973 which would add almost 40,000 physicians to the workforce in the next ten years, with preferences for primary care and general surgery.

Section 3032: Distribution of Additional Residency Positions

To help achieve an expanded physician workforce, we strongly urge Congress to lift the cap on Medicare-supported graduate medical education (GME) training slots. Additionally, Medicare's Indirect Medical Education (IME) adjustment should be preserved at its current level. Section 3032 of the "America's Healthy Future Act," as passed by the Finance Committee, does not accomplish this objective. It merely redistributes 65 percent of unused graduate medical education training slots—a number that will produce fewer than 250 additional physicians per year.

Sections 3033 / 3034: Counting Resident Time in Outpatient Settings and Allowing Flexibility For Jointly Operated Residency Training Programs / Rules for Counting Resident Time for Didactic and Scholarly Activities and Other Activities

The AAMC strongly supports Sections 3033 and 3034 for resolving problematic barriers to placing residents in non-hospital settings for a portion of their training.

Section 3035: Preservation of Resident Cap Positions from Closed and Acquired Hospitals

The AAMC strongly supports Section 3035 for preserving and redistributing Medicare-supported GME training slots from teaching hospitals that close. Since 1997, communities around the nation have lost residency training positions—and their future supply of physicians—when teaching hospitals have closed.

Section 3038: Increasing Teaching Capacity (Teaching Health Centers)

The AAMC supports increases in GME training capacity but strongly opposes Section 3038 for directing \$230 million in Medicare Part A funds to support residency training programs at "teaching health centers" (THCs). THCs will be based in community health centers (CHCs) and other related facilities that fall under the jurisdiction of the Public Health Service Act (PHSA). Funding for THCs should be appropriated under the PHSA and not the Medicare program. Medicare GME funding should be used as originally intended: to support positions in teaching hospitals that incur significantly higher costs due to their teaching missions. Additionally, GME

funding should continue to be tied to the care of Medicare beneficiaries. Only about 5% of CHC patients are Medicare beneficiaries.

Other Health Professions Education and Training Programs

Finally, we support provisions under Title IV of the Senate Health, Education, Labor and Pensions (HELP) Committee's health care reform bill (S. 1679) that reauthorize the existing health professions education and training programs under Title VII of the Public Health Service Act. We urge inclusion of these provisions in the final bill, to strengthen the programs and enhance their ability to improve the supply, diversity and distribution of the nation's health care workforce.

Geographic Variations in Medicare Spending

While some individuals suggest that the nation should move quickly to reduce variations in Medicare spending and resource utilization, multiple studies consistently indicate that such proposals are premature given a lack of data about the causes of this variation. Congress should carefully review and identify the many drivers of variations (e.g., income, race, previous coverage status) before it takes any action to alter payment policies related to spending and resource use. Additionally, Congress should carefully consider whether Medicare itself is an acceptable proxy for health care spending (and efficiency) without considering overall health expenditures.

Section 3003: Improvements to the Physician Feedback Program

The AAMC strongly opposes Section 3003 for arbitrarily reducing payments for physicians at or above the 90th percentile of national utilization rates. Such blunt payment reductions will disproportionately and unfairly penalize medical school faculty physicians who typically care for extremely sick and highly complex patients. The reductions may also discourage some physicians from providing beneficiaries with necessary health care services.

Section 3007: Value-Based Payment Modifier Under the Physician Fee Schedule

The AAMC strongly urges Congress to fully review both the premise and impact of Section 3007 before allowing the Secretary of Health and Human Services (HHS) to implement any related payment changes. As currently written, Section 3007 would potentially penalize medical school faculty physicians, who often provide costly yet innovative and life-saving health care services that are unavailable elsewhere in the community.

Medicare Physician Payments

Unless Congress intervenes, physicians face a 21.5 percent reduction in Calendar Year (CY) 2010 Medicare physician payments. Such a significant cut will have a direct and major impact on the ability of the nation's medical schools to fill their unique educational missions. The clinical revenue generated by faculty physicians represents about 38 percent of all financial support for medical schools. Medicare accounts for about one-quarter of that clinical revenue.

Section 3101: Increase in the Physician Payment Update

Section 3101 provides only one year of temporary relief from the scheduled 21.5% reduction in Medicare physician payments. It establishes a 0.5% update for CY 2010, but does not prevent subsequent reductions in 2011 and beyond. The AAMC strongly urges Congress to take immediate action to reform the problematic physician payment methodology and avert the future cuts. As major providers of Medicare physician services (an estimated one-sixth of all physicians in the Medicare system), medical school faculty and the missions they support will stagger under the dramatic Medicare payment reductions projected for the next several years.

Independent Medicare Commission

Section 3403: Medicare Commission

The AAMC believes that the Medicare Payment Advisory Commission (MedPAC), as currently structured, already serves as an adequately independent advisory body to Congress. MedPAC should continue in this role, which allows Congress to fully review and debate its recommendations. Such transparent interaction between the legislative and executive branches of our government is the most effective way to prevent unintended, yet potentially very harmful, consequences for patients and providers.

Access to Critical Lab Tests

Section 3114: Treatment of Certain Complex Diagnostic Laboratory Tests

The AAMC believes Section 3114 unfairly and unjustifiably advantages independent labs by allowing them (but not allowing hospital-based labs) to bill Medicare directly for certain “covered complex diagnostic laboratory tests” without regard to where the specimen was collected (e.g., during an inpatient hospital stay). We strongly urge either rejection or modification of the language to assure that independent and hospital-based labs operate on a “level playing field.”

Healthcare Innovation Zones (HIZs)

We strongly urge the Senate to offer and adopt an amendment adding the AAMC-supported Health Care Innovation Zones (HIZs) Pilot Program (H.R. 3664) to its health care reform legislation. This legislation would increase integration and align health care provider incentives to reduce the rate of health care cost growth while improving quality of care for Medicare, Medicaid and privately insured patients.

The HIZ is a geographic region that contains a teaching hospital, physicians and other clinical entities that would provide a full spectrum of health care and could provide for the incorporation of new and innovative clinical initiatives for training the next generation of health care providers. New innovations in clinical care would be developed and implemented by physicians and other

clinicians in an innovation zone that helps facilitate coordination of care, quality improvement and cost reduction.

The program would consist of two phases. The first phase would distribute planning grants to entities, comprising a teaching hospital and others, that would develop and submit HIZ design plans tailored to their own geographic region and address issues including, but not limited to, how providers would reduce the rate of increase in spending, how physicians, hospitals and other providers would collaborate and align to provide the full spectrum of care as well as collect, analyze and share data among the clinical partners. The proposals could include necessary exemptions from regulations and other barriers that impede integration and alignment. The second phase would be the implementation of a pilot program that would be based on the approved proposals but would also require that the participants provide care to at least 50 percent of the population within the HIZ and accept Medicare payments that are equal to a base level increased by a rate of growth that is 1.5 percentage points less than the project rate of growth for the HIZ.

Conclusion

The AAMC reiterates our great appreciation for your continued commitment to achieving comprehensive health care reform that benefits all Americans. We look forward to continued collaboration with you and your staff as we all work to assure enactment of policies that improve the health and security of our nation.

Sincerely,

A handwritten signature in black ink, appearing to read 'Atul Grover', with a long horizontal flourish extending to the right.

Atul Grover, MD, PhD, FACP, FCCP
Chief Advocacy Officer, AAMC