



Legislative Hearing on
Payments to Certain Medicare Fee for Service
Providers

Testimony to

**United States House of Representatives
Committee on Ways and Means
Subcommittee on Health**

by

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My name is Stanley Brezenoff and I am president and chief executive officer of Continuum Health Partners. Continuum is the parent company of four distinguished voluntary teaching hospitals in New York City, including Beth Israel Medical Center, St. Luke's and Roosevelt Hospitals, Long Island College Hospital, and New York Eye and Ear Infirmary. Continuum's partners offer an incredible array of innovative clinical programs and groundbreaking research projects. These endeavors exemplify the standards of excellence that are the centerpiece of our mission to provide the highest quality, most compassionate care to our patients. Let me also say that Continuum Health Partners is at a pivotal juncture in its eight-year history. Since our formation in 1997, we have taken major steps to establish a partnership that capitalizes on the expertise of some of the greatest medical and surgical talents in the country. During this same period, we have developed and implemented organizational and financial strategies that are helping us sustain the advances we have made as a major health care provider in the New York metropolitan region.

I am pleased to have the opportunity to testify before the subcommittee on behalf of the Association of American Medical Colleges (AAMC) and Greater New York Hospital Association (GNYHA) about the importance of Medicare's special payments to teaching hospitals.

The AAMC represents all 125 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs medical centers; and 96 academic and scientific societies representing 109,000 faculty members. GNYHA is a trade association comprising nearly 300 hospitals and continuing care facilities, both voluntary and public, in the metropolitan New York area and throughout New York State, as well as New Jersey, Connecticut, and Rhode Island. GNYHA members include academic medical centers, major teaching hospitals, and community hospitals, many of which also have teaching programs.

Continuum is also a member of the American Hospital Association (AHA). *I wish to endorse the AHA's testimony concerning the FY 2008 Inpatient PPS Proposed rule, the hospital payment cuts proposed in the president's FY 2008 Medicare budget, the 75 percent rule for rehabilitation services, and specialty hospitals. While not the subject of this hearing, I would also like to express the AAMC and GNYHA's strong support for reauthorization and expansion of the State Children's Health Insurance Program so that the United States can provide health insurance coverage for all of our children.*

The Role of Teaching Hospitals in Serving the Nation's Patients and Medicare Beneficiaries

Teaching hospitals have a unique role in our nation's health care system. In addition to providing basic health services to their communities and Medicare beneficiaries, such as primary and secondary patient care, teaching hospitals are also responsible for providing education for all types of health care professionals; an environment in which clinical research can flourish; and 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 services and equipment; and with residents and supervising physicians available around-the-clock, teaching hospitals care for the nation's sickest patients. As shown in the attached graphs, teaching hospitals tend to provide more advanced and specialized services than non-teaching hospitals.

Providing almost half of all inpatient care, teaching hospitals also provide a significant amount of charity care. Indeed, our nation's teaching hospitals provide large amounts of ambulatory care in poor communities, often acting as the "family doctor" in areas where few individual practitioners exist, accept Medicaid as a form of payment, or provide charity care. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical, or nuclear attack and are implementing plans to fulfill that role.

Not only are teaching hospitals invaluable providers of care, but teaching hospitals and their affiliated medical schools are major contributors to our nation's economy. According to "The Economic Impact of AAMC-Member Medical Schools and Teaching Hospitals" conducted by consulting firm Tripp Umbach, the nation's allopathic medical schools and teaching hospitals represented by the AAMC had a combined economic impact of \$451 billion on their states and the nation in 2005, employ nearly 1,670,000 individuals, and are directly and indirectly responsible for more than 3 million full-time jobs—one out of every 48 wage earners in the United States.

Our mission to teach the next generation of physicians has never been more important. Indeed, according to the U.S. Census Bureau, the number of elderly will double by 2030. With this will come a sizable increase in demand for health care services. According to data from the National Ambulatory Medical Care Survey, patients aged 65 and older typically average six to seven physician visits per year. If the annual number of physician visits continues at this rate, the U.S. population will make 53 percent more trips to the doctor in 2020 than in 2000, which means that we will need to produce many more physicians per year than we are producing now. The Health Resources and Services Administration's (HRSA) Bureau of Health Professions projects that the nation will have a shortage of at least 55,000 physicians by the year 2020. This has enormous implications for health care policy. Indeed, given the amount of time it takes to educate and train a physician—four years of medical school, plus multiple years of residency training—2020 is now, and we must take action immediately. In fact the Federal Council on Graduate Medical Education (COGME) issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, that recommended that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased.

Medicare Special Payments to Teaching Hospitals

For 40 years, Medicare has played a critical role in ensuring that the important services provided by teaching hospitals are available to Medicare beneficiaries and other patients. AAMC teaching hospitals provide a disproportionate amount of health care services for

Medicare beneficiaries. Accounting for approximately 8 percent of all PPS hospitals, nearly one-fifth of all Medicare discharges (a total of 2 million discharges) are from AAMC teaching hospital members, also known as the Council of Teaching Hospital and Health Systems (COTH). 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 hospitals.

Medicare has recognized and provided its share of financial support to teaching hospitals for their unique roles extending beyond the traditional patient care service mission. Such payments include the Indirect Medical Education (IME) Adjustment, Direct Graduate Medical Education (DGME) and Disproportionate Share Hospital (DSH) payments.

The Indirect Medical Education Adjustment

In recognition that the additional missions of teaching hospitals increase the operating cost of patient care and that differences exist in operating costs between teaching and non-teaching hospitals, the Medicare program includes a special payment adjustment in its prospective payment system (PPS) known as the IME adjustment. Unfortunately, the IME adjustment is mislabeled and 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 identified the rationale behind the adjustment:

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 given hospital's IME payment is determined by 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. In FY 2008, each DRG payment a hospital receives will be adjusted upwards from its basic rate by approximately 5.5 percent for every 10 residents per 100 beds in that hospital. The Balanced Budget Act of 1997 (BBA) initiated the start of a multiyear 30 percent across-the-board reduction in the IME adjustment, from 7.7 percent to 5.5 percent.

The BBA also made changes in how residents are counted for the IRB, a key variable in the IME formula. A limit was placed on the number of full-time equivalent (FTE) residents in allopathic and osteopathic training programs that a hospital can count for

purposes of receiving IME payments in either a hospital or non-hospital setting. In general, the number of residents can not exceed the number of residents counted during the hospital's most recent cost report period ending on or before December 31, 1996. Beginning in FY 1998, hospitals are permitted to count residents in a non-hospital setting for IME payment purposes if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Medicare Direct Graduate Medical Education Payments

Medicare also helps offset its share of the direct costs of educating medical residents through the DGME payment. DGME payments are based on the costs associated with residents' stipends and fringe benefits, the salaries and fringe benefits of faculty who supervise residents, other direct costs, and allocated overhead costs. Other direct costs include the costs of clerical personnel who work exclusively in the GME administrative office or other directly assigned costs.

From 1965 until 1985, Medicare paid for its share of DGME costs based on each hospital's historical "Medicare-allowable" DGME costs. Reimbursement was open-ended: if a hospital increased its DGME costs, the Medicare program would pay its share of the allowable costs incurred.

However, in April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), which dramatically changed the DGME payment methodology in two ways. Under this new method, Medicare pays hospitals its proportionate share of a hospital-specific capitated, or per resident, amount. In addition, the Medicare program limits the number of years for which it fully supports its share of residency training, with hospitals that train residents in subspecialty residency programs receiving only 50 percent of the Medicare DGME payment.

To determine the per resident payment amount, a hospital calculates its base year (usually FY 1984) Medicare-allowable DGME costs, and divides that figure by the average number of FTE residents present in all areas of the hospital complex in that year. The per resident amount is then updated from the base year using the Consumer Price Index (CPI) and multiplied by the number of residents in the payment year. Medicare's share of this total dollar figure is calculated by multiplying it by the ratio of Medicare inpatient days to total inpatient days. There are some important details concerning how the FTE resident count is determined, several of which I will discuss later.

Like the IME payment, there is a cap on the number of residents for which a hospital may receive DGME payments.

Disproportionate Share Hospital Payments

Because of the special missions of academic medical centers and teaching hospitals, many serve a disproportionate share of low-income individuals and thus receive Medicare Disproportionate Share Hospital Payments (DSH). Congress established such payments in the 1980s to recognize the higher costs incurred in treating a disproportionately high number of low-income patients and to ensure access to care for

Medicare patients. DSH payments are intended to support those hospitals that provide a disproportionate amount of care to the poor and are available only if a threshold "disproportionate share patient percentage" is met or exceeded. The current formula used to calculate the disproportionate share patient percentage is based on the amount of care provided to patients who receive Medicaid and Supplemental Security Income benefits.

In addition to the disproportionate share patient percentage, the level of Medicare DSH that hospitals receive is based on their status as an urban or rural provider and their bed count. Specific formulae are used to calculate DSH payments as percent add-ons to Medicare DRG rates. These formulae and the qualifying patient percentages were modified by Congress in 2000 and in 2003 to create greater equity among urban and rural providers.

The Financial Picture for Major Teaching Hospitals

The missions of teaching hospitals have important financial consequences. Thus, it is not surprising that the aggregate total margin for the nation’s major teaching hospitals is consistently and significantly below that of other hospital groups. In some years, the margins have hovered near zero. In 2004, the most recent and complete data available, the aggregate total margin for major teaching hospitals (those with an intern/resident-to-bed (IRB) ratio of 0.25 or more) was only 3.4 percent; half of teaching hospitals had total margins less than 2.4 percent. By contrast, the aggregate total margin for other teaching hospitals was 5.0 percent, and 4.7 percent for non-teaching hospitals.¹

Total margins often reflect the “best-case” scenario for hospitals because they reflect revenues associated with non-patient care activities. Operating margins reflect a much bleaker picture for major teaching hospitals. The 2004 aggregate operating margin was -8.3 percent, with the typical major teaching hospital having a -5.0 percent operating margin (the average was -10.5 percent). By contrast, other teaching and non-teaching hospitals had aggregate operating margins of 0.6 percent and 1.5 percent respectively.

Hospital Total and Operating Margins, by Teaching Status, 2004						
Hospital Type	Total Margin			Operating Margin		
	<i>Aggregate</i>	<i>Average</i>	<i>Median</i>	<i>Aggregate</i>	<i>Average</i>	<i>Median</i>
Major Teaching	3.4%	1.5%	2.4%	-8.3%	-10.5%	-5.0%
Other Teaching	5.0	2.9	3.6	0.6	-1.5	-0.6
Non-Teaching	4.7	2.5	3.3	1.5	-2.0	-0.5
<i>Source: Vaida Health Data Consultants, Analysis of Medicare HCRIS Database, June 30, 2006 Update</i>						

¹ 2004 Margin Analysis conducted by Vaida Health Data Consultants (using the June 30, 2006 HCRIS Update). Unless otherwise indicated, all margin figures were obtained from this analysis.

The special payments made by Medicare to teaching hospitals help ensure the hospitals' financial viability. Thus, it is not surprising, and is quite consistent with the missions of these payments, that Medicare margins for major teaching hospitals are higher than for other groups. In addition, because the primary purpose of Medicare DSH payments is to help offset the costs associated with uninsured patients rather than Medicare patients, we believe that these payments should be excluded when calculating Medicare inpatient and Medicare overall margins. When these payments are removed, both aggregate Medicare inpatient and overall margins for major teaching hospitals are significantly reduced.

Hospital costs and cost growth are key components when assessing hospitals' financial conditions. Because of their fragile overall financial conditions, major teaching hospitals must be diligent about resource spending. Despite unprecedented cost pressures, major teaching hospitals have been able to constrain their cost growth below that of other hospital groups. Between 2000 and 2004, Medicare operating costs per case (adjusted for case mix) grew an average of 5.5 percent for major teaching hospitals, compared to a growth of 6.4 percent for other teaching hospitals, and 6.6 percent for non-teaching hospitals.²

Ensuring Adequate Medicare Resources for Teaching Hospitals, Their Medicare Patients, and Communities

Teaching hospitals provide important societal missions on razor-thin margins. It is critical that policymakers and academic leaders work together to ensure, as was promised in 1965, that Medicare continues to support the vital missions of teaching hospitals that represent the cornerstone of America's health care delivery system. The AAMC and GNYHA therefore call upon the Congress to commit to protect these vital and critical resources of the national health care system by actively working with us on implementing the following agenda.

1. Oppose the President's FY 2008 Medicare and Medicaid Budget Proposals That Cut Teaching Hospital Payments

The president's FY 2008 budget proposes to cut \$101.5 billion from the Medicare and Medicaid programs over five years. President Bush's Medicare budget proposes \$76 billion over five years in legislative and regulatory cuts from hospitals and other providers, including approximately \$14 billion in inpatient and \$3 billion in outpatient reductions. All of the proposals that would negatively affect hospital payments are of concern to teaching hospitals. We commend and join Representatives Richard Neal (D-Mass.), Phil English (R-Pa.) and 221 other members of Congress who have urged the House Budget Committee leaders to reject cuts to Medicare and Medicaid hospital funding in the FY 2008 budget resolution.

Two specific proposals solely affect teaching hospitals: the elimination of teaching hospitals' Medicare IME payments associated with treating Medicare Advantage beneficiaries and the elimination of Medicaid funding for graduate medical education.

² AHA analysis of Medicare operating cost per case growth, using the March 31, 2006 HCRIS Update.

Teaching Hospital Medicare IME Payments Associated with Treating Medicare Advantage Enrollees

Included in President Bush's Medicare budget is a legislative proposal to "eliminate duplicate IME payments to hospitals for MA beneficiaries." The proposal would eliminate IME payments that are made directly to teaching hospitals when they care for Medicare Advantage (MA) enrollees.

The BBA of 1997 established mechanisms to directly reimburse teaching hospitals for DGME and IME payments associated with Medicare managed care patients to prevent the degradation of the academic medicine infrastructure under managed care. These payments were financed by "carving out" the payment from the managed care rates.

Teaching hospitals are between a rock and a hard place in a managed care environment because the economic imperative for managed care plans is either to negotiate lower teaching hospitals' rates by excluding payments for DGME and IME or contracting with lower cost non-teaching hospitals wherever possible. Either way, teaching hospitals would lose by accepting inadequate payments to hold onto their business or by losing the business to lower-cost non-teaching hospitals.

The BBA anticipated this problem when it created the Medicare+Choice program, the precursor to MA, by calling for the separate payment of the DGME payment and IME payment to teaching hospitals for HMO enrollees, thus removing the issue of teaching hospitals' higher costs from the negotiating table and ensuring the integrity of the nation's training and biomedical research infrastructure. In 2002, MedPAC supported this mechanism in its *Report to the Congress: Medicare Payment Policy*.

However, when Congress set MA plan rates with the enactment of the Medicare Modernization Act of 2003, it added back IME payments to the MA benchmark payment rates.

The president's proposal is based on the premise that the IME payment is being paid twice in the Medicare Advantage program-- once to health plans in their rates and once directly to teaching hospitals. Instead of returning to the BBA's original concept—namely, a "carve out" from plan premiums—the president's budget proposal eliminates the direct payments to teaching hospitals. It should be underscored that teaching hospitals are not receiving the IME twice. This is because the law requires noncontracted hospitals to accept as payment in full the amount that Medicare would have paid through fee-for-service (FFS) rates, effectively capping any hospital's MA payment at the FFS equivalent.³ If a hospital has a contract with an MA plan, its payment is often less

³ 42 C.F.R. §422.214(b) states: "(a) Services furnished by section 1861(u) providers of service. Any provider of services as defined in section 1861(u) of the [Social Security] Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan, an MSA plan, or an MA private fee-for-service plan must accept, as payment in full, the amounts (less any payments under §§412.105(g) and 413.76 of this chapter) that it could collect if the beneficiary were enrolled in original Medicare. (Section 412.105(g) concerns indirect medical education

because the health plan can often negotiate down from this fee-for-service cap. This is because if the “worst” that could happen to a plan when a hospital is not in a health plan’s network is that the plan has an obligation to pay the fee-for-service amount less IME payments, health plans have no reason to pay more to persuade a hospital to contract with it.

If President Bush’s budget proposal were to be enacted, it would strip away the IME payment made directly to teaching hospitals, causing losses in the nation’s teaching hospitals of more than \$600 million per year. Teaching hospitals might try to negotiate higher payments from MA plans to make up for the loss, but would probably be unsuccessful because of the dynamics and economic pressures of the negotiated rate market described above.

We oppose this proposal and urge Congress to protect these much-needed payments to teaching hospitals. If Congress is seeking savings from the Medicare program, we believe that one source of legitimate savings would be to remove IME payments from the MA rates, while continuing to make IME payments directly to teaching hospitals when they serve MA enrollees.

Medicaid’s Support for Graduate Medical Education

The AAMC and GNYHA realize that this committee does not have jurisdiction over the Medicaid program. However, in light of the committee’s interest in the viability of teaching hospitals and the safety net, we want to ensure that the committee is aware we are opposed to the president’s Medicaid proposal that “clarifies” that Medicaid “will no longer be available as a source of funding for [Graduate Medical Education].” This proposal is estimated to save \$1.8 billion over 5 years.

Many state Medicaid programs have long recognized the need to make additional payments to teaching hospitals to help offset additional costs these facilities incur as a result of their special missions of educating physicians and caring for patients who require more intense, complex care. Following Medicare’s lead, many states have implemented two payments similar to Medicare’s IME adjustment and DGME. Such payments are not intended to offset the full level of additional costs incurred by teaching hospitals, but instead pay Medicaid’s “share” of these costs. According to a study commissioned by the AAMC, in 2005, 47 states and the District of Columbia provided DGME and/or IME payments under their Medicaid programs. The nation’s major teaching hospitals provide a disproportionate amount of health care services for Medicaid beneficiaries and the uninsured, while simultaneously maintaining core missions of medical education, biomedical research, and innovative patient care. Approximately 24 percent of all Medicaid discharges are from major teaching hospitals. Major teaching hospitals provide nearly one-half (45 percent) of all hospital charity care.

payment to hospitals for managed care enrollees. Section 413.76 concerns calculating payment for direction medical education costs.)”

Given these times of increasing financial uncertainty for America's teaching hospitals, *it is important that the Medicaid program and states be allowed to maintain their financial commitments to teaching hospital missions.* We appreciate Congress' desire to intervene by including in HR 2206, the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 a one-year moratorium of the implementation of this proposal.

2. Reject the Medicare Payment Advisory Commission's March 2007 IME Recommendation

On March 1, 2007, the Medicare Payment Advisory Commission (MedPAC) released to Congress its *2007 Report to the Congress: Medicare Payment Policy*. The teaching hospital community was extremely distressed that MedPAC adopted the following recommendation in its *Report*:

Concurrent with implementation of severity adjustment to Medicare's diagnosis group related payments, the Congress should reduce the indirect medical education adjustment in fiscal year 2008 by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The funds obtained from reducing the indirect medical education adjustment should be used to fund a quality incentive payment system.

We appreciate and share the Commission's desire that the diagnosis-related group (DRG) system be modified to better reflect patient severity. Major teaching hospitals tend to treat the sickest and most complex patients. Providing Medicare payments that more closely align with the higher costs of treating these patients makes sense from both policy and practical perspectives.

We are concerned, however, about linking an IME payment reduction with this change. First and foremost, the overall financial condition of major teaching hospitals does not support any reduction in IME payments. Also, reducing the IME by one percentage point from 5.5 percent to 4.5 percent represents a 20 percent reduction in total IME payments.

Second, MedPAC's recommendation to reduce IME payments is premised on implementation of a severity adjustment. As you know, CMS has not implemented such an adjustment but has only recently proposed an overhaul of the current DRG system by creating 745 new Medicare-severity DRGs to replace the current 538 DRGs. We are currently reviewing the impact of this proposal and it is not yet known to what extent such a system will fully address patient severity cost differentials.

Moreover, CMS has recently implemented, or is considering implementing, a number of other changes to the DRG system that will, or could have, a significant impact on teaching hospitals. These include adding an occupational mix adjustment to the hospital wage index, other changes to wage index policies, and altering the standardization process when setting DRG weights.

We believe that MedPAC's recommendation to reduce the IME adjustment is, at best, premature. For these reasons, the AAMC and GNYHA urge Congress to reject the MedPAC recommendation.

3. Lift Medicare's Resident Limits

Section 4621 of the BBA limited the number of allopathic and osteopathic medical residents that could be counted for purposes of calculating teaching hospitals' Medicare IME and DGME reimbursement. In general, effective October 1, 1997, to the extent the number of allopathic or osteopathic residents being trained at teaching hospitals exceeds their 1996 limits, teaching hospitals receive no additional IME or DGME payments. Podiatry and dental residents are excluded from the resident limits.

The academic medicine community understood at the time the BBA was passed and signed into law 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, like many others, could contribute toward bringing about a balanced budget. The other reason was to address the conventional wisdom of the early to mid-1990's regarding an impending oversupply of physicians. This conventional wisdom was predicated in large part on reports that had been published in the early 1990s by the 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, in deciding to include the resident cap provision within the BBA, Congress sought to significantly limit the production of physicians and respond to the then-conventional wisdom regarding a looming physician oversupply.

Section 407 of the Balanced Budget Refinement Act of 1999 (BBRA) increased the limit for rural teaching hospitals to equal 130 percent of each rural teaching hospital's 1996 resident count and Section 422 of the Medicare Modernization Act of 2003 created a one-time program to reduce the Medicare resident caps for hospitals with below-cap resident counts and "redistribute" them to hospitals seeking to expand their caps.

Despite the cap adjustment for rural teaching hospitals, and the 2005 implementation of the resident limit redistribution program, the BBA's overall resident limit policy continues to impose significant limitations on the ability of teaching hospitals and medical schools sponsoring and conducting graduate medical education programs to respond to the needs of the communities they serve. The growth and aging of our population now indicate a very different future. According to the U.S. Bureau of the Census, the elderly population in the U.S. is expected to *double* between 2000 and 2030. Because of this rise in the number of elderly and a number of other factors, demand for

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).

physician visits is expected to increase by 53 percent between 2000 and 2020, according to an analysis performed by the AAMC using data gathered from the National Ambulatory Medical Care Survey. Currently, the vast majority of health policy analysts and physician workforce researchers have concluded that the forecasts made 10 years ago were in error because they were based upon the presumption that the entire US health care system would change due to managed care. In fact, many states and physician specialties are reporting current shortages.

Clearly, the current limitations on the number of residents Medicare will support ignores current and future physician shortages experienced in many states and in many specialties. COGME issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, recommending that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased. The COGME report's analysis indicated that while the supply of physicians is expected to increase over the next two decades, demand for services is likely to grow even more rapidly. According to the report, the three major factors driving the increase in demand will be the projected U.S. population growth of 18 percent between 2000 and 2020, the aging of the population as the number of Americans over 65 increases from 35 million in 2000 to 54 million in 2020, and the changing age-specific per capita physician utilization rates, with those under age 45 using fewer services and those over age 45 using more services. The report notes that changing work patterns of physicians, such as decreases in working hours, could lead to greater shortfalls, while increases in productivity may moderate any shortfalls. As a result of the overall trends, however, the report recommended an increase in U.S. medical school production by 15 percent and noted, "the current cap on the number of residents and fellows eligible for Medicare reimbursement strongly discourages teaching hospitals from increasing the number of residents."

In October of 2006, the HRSA's Bureau of Health Professions issued a report examining the physician workforce through 2020.⁵ This report suggested that, by 2020, the number of primary care physicians will grow 18 percent while demand for their services are likely to grow somewhere between 20 percent and 30 percent. While HRSA has historically focused on access to primary care services, they suggest an even larger shortfall of non-generalist physicians. By 2020, the number of non-primary care physicians will grow by about 10 percent while demand for their services—driven largely by the elderly—will grow between 25 percent and 45 percent, leaving a shortfall which will not be met without expanding the physician workforce and concurrently improving the efficiency of care delivery.

Because of physician workforce needs and the commitment to their educational missions, states, medical schools, and teaching hospitals are already beginning to respond to the nation's physician shortage needs by creating new medical schools or expanding medical school class size, expanding residency programs or creating new ones. The AAMC is calling for a 30 percent increase in medical school enrollment over the next decade, and

⁵ <http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/default.htm>

AAMC surveys of U.S. medical school deans indicate that most growth will occur in public institutions and in those states where population growth has far outpaced the infrastructure for medical education. In addition to M.D. granting schools, osteopathic schools are also planning increases. New and existing D.O. schools are expected to increase enrollment by 2,000 to 3,000 per year over the next decade.

Teaching hospitals have increased the number of residents they train beyond their 1996 caps in accordance with greater need for current and future physician services. According to AAMC analysis, based on 975 teaching hospitals reporting both cap and count data on FFY 2004 Medicare cost reports, 464 hospitals are over their resident caps by an aggregate count of about 4,900 positions. These hospitals receive no Medicare IME or DGME support associated with these additional residents.

Given the extended time required to increase U.S. medical school capacity and to educate and train physicians, the nation must begin now to increase medical school and GME capacity to meet the needs of the nation in 2015 and beyond when demand for services are expected to outstrip physician supply. A shortage of physicians would undeniably make access to care more problematic for all citizens, particularly those that are already underserved. Such shortages would increase the delays individuals encounter in scheduling appointments and the distances they will need to travel for various types of health care services. Shortages would be especially problematic for the disadvantaged who already encounter substantial barriers to health care services. Congress must do its part to recognize the current and future needs for more physicians and pass legislation to eliminate the Medicare resident cap.

4. Congress Should Work With CMS to Clarify in Statute That the Medicare Program Is Intended to Support All Resident Training Time

The academic medicine community has come under increasing pressure from policymakers to take a greater leadership role in educating and training physicians who are able to respond to the various challenges presented by an increasingly diverse and complex health care system. For example, there has been increasing focus in recent years on cultural and linguistic issues in the delivery of health care and how the relatively little attention given to these matters in the physician education curriculum might be a contributing factor to disparities in health care outcomes. In addition, more and more treatments are available on an outpatient basis as a result of significant biomedical advances and this has created a need for alternative training settings outside the traditional acute inpatient unit.

Medical schools and teaching hospitals have responded to these demands for change by incorporating a variety of new educational strategies into their curricula so that physicians-in-training are better prepared to address these issues. The Accreditation Council for Graduate Medical Education, which accredits all allopathic physician residency training in the U.S., has incorporated six core educational competencies within the accreditation requirements for all training programs and has modified specialty requirements to ensure that appropriate experience in the outpatient setting is included. In

order for teaching hospitals and residency programs to maintain their accreditation (and receive needed Medicare reimbursement), they must ensure that special educational seminars, workshops, lectures and other didactic strategies are included as part of the curriculum, and that residency training activities occur in a variety of settings. The AAMC and GNYHA support this movement as it only serves to improve the preparation of tomorrow's physicians.

Unfortunately, CMS's Medicare DGME and IME regulations regarding physician training in nonhospital settings and treatment of educational (other than direct patient care) activities are creating disincentives for exactly the kind of educational strategies that policymakers want the academic medicine community to promote.

In recent years, much to the dismay of the academic medicine community, CMS has promulgated Medicare regulations that have had the unfortunate effect of disallowing certain legitimate physician resident training activities for purposes of Medicare direct and/or indirect medical education reimbursement. In addition to these financial penalties, the effect of these complex regulations has been to add to the already significant administrative burdens on teaching hospitals.

The AAMC and GNYHA have forcefully expressed their disagreement with CMS's view that the Agency is required under the statute to assess the exact nature of particular physician resident activities. The practical reality is that physician resident training is a fluid activity that comprises direct patient care, educational activities related to patient care, and research activities intended to support patient care. Except in certain specific and very limited cases (e.g., a defined special research assignment that is separate and apart from the ordinary course of education and training), the activities blend together to form a seamless whole that is not amenable to the parsing that the Agency seeks to impose. And we believe in particular that this parsing was never intended or expected by Congress. The Agency has generally indicated that they are simply "implementing Congress's intent" and that the Agency is "bound by the language in the statute." For this reason, the AAMC and GNYHA urge Congress to work with CMS to set clear and simple rules that will allow Medicare GME reimbursement in the manner in which the academic medicine community believe it was intended. Following are descriptions of several CMS policies that seek to parse physician resident time, and an example of how the Agency seems to be expecting the time to be tracked for Medicare reimbursement purposes.

Training in Nonhospital Settings

In recognition of the importance of residency training in ambulatory sites, Congress authorized teaching hospitals to receive DGME and IME payments associated with residents training in nonhospital sites, such as physicians' offices, if they incur "all or substantially all" of the training costs. In 1999, CMS issued a regulation defining "all or substantially all" of the training costs as the residents' stipends and benefits plus physician supervisory costs

CMS recently finalized a regulation that is intended to make it administratively easier for teaching hospitals to count the time that residents spend in nonhospital settings. While the academic medicine community appreciates CMS's efforts to simplify matters, the regulations still involve a significant documentation burden associated with tracking this time. More fundamentally, we vigorously disagree with CMS's interpretation of the statutory "all or substantially all" requirement because the regulations fail to recognize that many supervising physicians volunteer their time. This failure on the part of CMS to recognize the nature of physician voluntarism is what causes the bulk of the administrative burden that is associated with this particular policy.

The academic medical community has a long tradition of physician volunteers. We believe that through negotiation the hospital and nonhospital site should determine whether there are supervisory costs and, if so, the level of those costs. Further, if physicians state they are volunteering as supervisors, CMS should not require hospitals to pay supervisory costs. We urge Congress to clarify the definition of "all or substantially all" training costs at the nonhospital site to mean the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity operating the nonhospital setting. We commend Reps. Kenny Hulshof (R-Mo.) and John Tanner (D-Tenn.) for their leadership in sponsoring past legislation entitled "the Community and Rural Medical Residency Preservation Act" that would do just that.

Engaging in Educational Activities

In the federal fiscal year 2007 IPPS proposed rule, CMS sought to "clarify" the agency's position that it does not provide Medicare IME reimbursement for educational activities such as conferences, seminars, and workshops in any setting and does not provide Medicare DGME reimbursement for these activities if they are held in a nonhospital (e.g., affiliated medical school) setting because these activities are not "related to patient care." This so-called clarification came as a shock to the academic medicine community, so much so that CMS received more than one thousand comment letters objecting to the proposal. The comments reminded CMS that didactic activities are an integral component of the patient care activities engaged in by residents during their residency programs. Moreover, the nature of physician residency training is that these educational activities are intertwined throughout the physician residency training experience and cannot be separated as CMS seemed to believe that they could. In the 2007 IPPS final rule, CMS responded by reiterating that these activities were not reimbursable, but that teaching hospitals could invoke a "one-day documentation threshold."

This means that hospitals would not be required to keep track of didactic activities that were less than a day in length. However, according to CMS, if hospitals do maintain resident documentation at a detailed level or on audit the fiscal intermediary "comes across" such activities, the time will be excluded from the resident FTE count.

Vacation and Sick Leave

In a continuation of its efforts to exclude resident time that is not directly related to treating patients, as part of the federal fiscal year 2008 IPPS proposed rule now in the comment period, CMS has gone still further and clarified that vacation and sick time

should not be countable at all when considering resident time. That is, not only should it not be reimbursable by Medicare (removing it from the numerator), it should not be considered countable time at all (removing it from the denominator). While the AAMC and GNYHA are grateful that it is being removed from both the numerator and denominator, we are extremely frustrated at yet another case of micromanaging the exact nature of physician resident “time” and what category it falls into and how it should be treated. The AAMC and GNYHA will be submitting comments to CMS expressing our frustration that so much time and energy is being spent engaging in this kind of parsing when the academic medicine community is simply seeking to have each physician resident be considered as one full 100 percent FTE when calculating direct GME and IME payments (notwithstanding that resident fellows are counted as a 0.5 FTE for other reasons when determining direct GME payments).

Example of How All This Time Would Need to be Tracked

To illustrate the inherent complexity of physician resident activities and the onerous administrative expectations by CMS for hospitals to track the time associated with these activities, consider the example of a physician resident training in her second year of an internal medicine program. In the course of one week, the resident may spend the bulk of her time training on a medical-surgical inpatient unit in a hospital with one afternoon set aside for going to a physician’s office to see patients for primary care visits, one morning set aside for a morbidity and mortality (M&M) conference, and she may also have the misfortune of needing to call in sick one day. The teaching hospital would like to simply note that all this time counts as one full week of reimbursable time. Previously, this would have been generally acceptable. Now, however, the hospital would seemingly be expected to:

- determine the actual number of days and hours that the resident was performing any training activities in the week (this is to determine the denominator from which to start subtracting time);
- determine whether any of the time may be viewed as voluntary and not part of the approved program (e.g., going to the library to study);
- subtract out the sick day (or hours) from the time to get a new denominator to start from;
- subtract out the scheduled M&M conference time from the total number of hours for purposes of the IME count;
- determine whether the scheduled M&M conference took place in a nonhospital setting so that it can be subtracted from the direct GME count of time;
- determine whether the assignment at the physician’s office is covered under a separate written agreement;
- determine whether the hospital has reimbursed the physician’s office a CMS-approved amount in order to count the time at all; and
- determine whether any other nonpatient care activities took place in the hospital, at the physician’s office, or at another nonhospital setting (e.g., an affiliated medical school).

The AAMC and GNYHA recognize that CMS's role is to ensure that its regulations reflect congressional intent, and if the statutory language is not exact enough to permit CMS to establish regulations that simplify this time tracking, the agency must sometimes make difficult distinctions. If the language within the statute needs further clarification and simplification to demonstrate Congress's intent that Medicare should fully support its fair share of the costs of training physician residents, we strongly urge Congress to do so so that the academic medicine community will no longer be weighted down with these severe administrative and documentation burdens.

The AAMC and GNYHA therefore recommends that Congress work with CMS to clarify in statute that the Medicare program is intended to support its fair share of all approved resident training time for both direct GME and IME.

5. Implement a Stable and Equitable Physician Payment Formula

While the focus of this hearing has been on hospital, home health, and skilled nursing facility payment systems, the AAMC and GNYHA want to reiterate that they are greatly concerned by the projected 10 percent reduction in Calendar Year (CY) 2008 Medicare physician payments. Unless Congress and the Bush Administration work together to resolve the fundamental flaws in the Sustainable Growth Rate (SGR) methodology used to calculate physician payment updates, the Medicare Trustees predict additional cuts of approximately 5 percent annually through CY 2016.

Under teaching hospitals' long-standing relationship with medical schools, medical school full-time clinical faculty ("teaching physicians") care for a large segment of teaching hospitals' inpatients and outpatients. Nationwide, over 97,000 teaching physicians have partnered with major teaching hospitals to provide a full range of clinical services, including cutting-edge care often unavailable elsewhere in the community. These same physicians also work with us to train medical students and residents; conduct clinical research that advances health care prevention, diagnosis, and treatment options; and provide health care for all Americans, regardless of their ability to pay for care.

Medicare physician payment cuts will exacerbate the ever-increasing financial pressure on teaching physicians to produce clinical revenue, which represents about one-third of total medical school revenue. One-quarter of that clinical revenue comes directly from Medicare. Our medical school partners will find it increasingly difficult to maintain their missions of medical education, clinical research, and patient care while facing reductions in Medicare reimbursement. It could also jointly affect our capacity to provide charity care and stand-by disaster readiness for the communities we serve.

The impact of Medicare physician cuts on teaching hospitals and our affiliated teaching physicians will be compounded further if community-based physicians restrict their acceptance of new Medicare beneficiaries or begin to limit access to less profitable Medicare services. Teaching hospitals and our teaching physician partners, which historically accept all patients regardless of their health coverage, would likely see an increase in our volume of Medicare patients, without receiving adequate reimbursement for Medicare services.

In light of the close relationships between teaching physicians and teaching hospitals across the country, we are very concerned by the immediate and direct impact Medicare physician payment reductions will have on our ability to maintain medical education, clinical research, and patient care missions.

We urge you to work with the administration to prevent the negative updates projected for the next few years, and we urge you to work with the physician community to implement a stable and equitable physician payment formula.

6. Support An IME Adjustment in Outpatient PPS

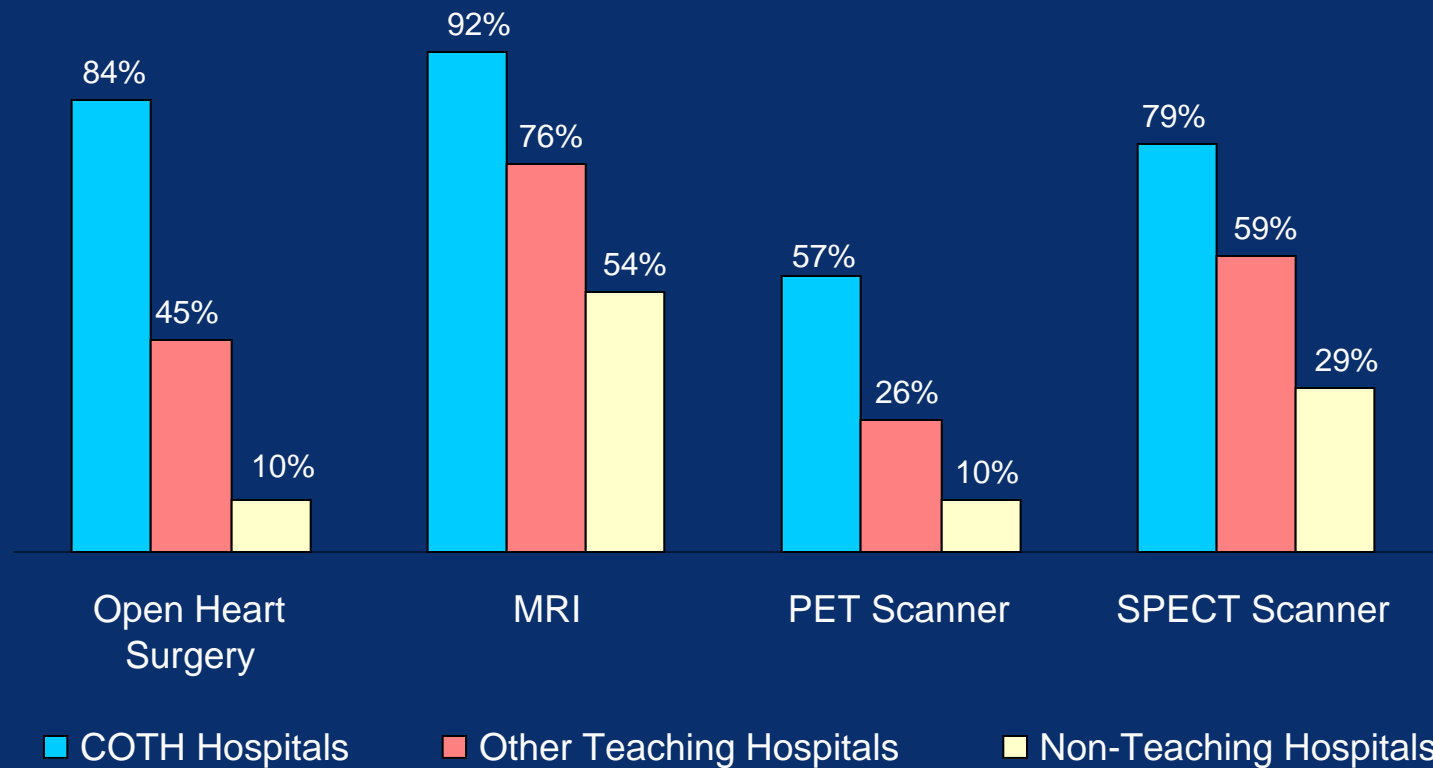
We urge Congress to ask CMS to conduct an analysis to determine whether an IME-type adjustment should be implemented in the outpatient PPS. Major teaching hospitals have negative Medicare outpatient margins significantly lower than those of other hospital groups,⁶ indicating that the outpatient PPS may not appropriately reflect services provided and patients treated in teaching hospitals' emergency rooms and outpatient clinics. The outpatient PPS statute provides CMS with the authority to include an IME adjustment, and the recently implemented prospective payment systems for both psychiatric and rehabilitation facilities contain IME adjustments.

Conclusion

For 40 years, Medicare has played a critical role in ensuring that the important services provided by teaching hospitals are available to Medicare beneficiaries and other patients. We believe strongly that if Medicare's support for teaching hospitals further deteriorates or waivers, then the very missions that the teaching hospitals support will be in jeopardy. If teaching hospitals' patient care, research and educational infrastructure begins to falter, the effects will be extremely difficult to reverse. I thank you for the opportunity to testify today. The AAMC and GNYHA look forward to working closely with this Subcommittee on these issues, which are of such importance to the health and well-being of our nation's seniors and, indeed, all Americans.

⁶ In 2004, major teaching hospitals had a -17.5 percent aggregate Medicare outpatient margin, compared to -7.3 percent for other teaching hospitals, and -8.0 percent for non-teaching hospitals.

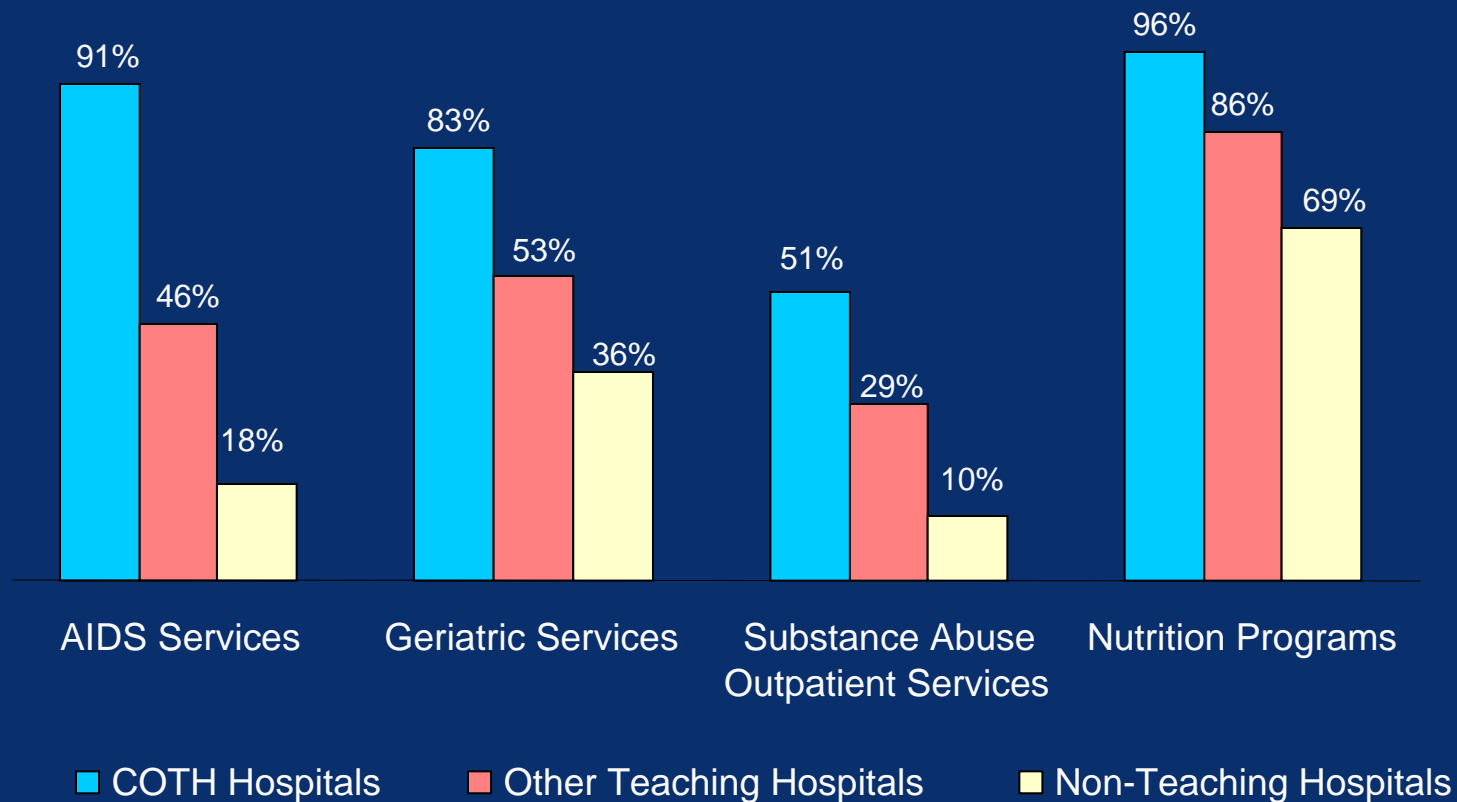
Comparison of Selected Hospital-Based Services Provided by COTH, Other Teaching, and Non-Teaching Hospitals



Source: AAMC analysis of AHA Annual Survey Database, FY2003.

- Note:
- 1) Percentages equal the number of institutions that offer the selected service divided by the total number of institutions in the category.
 - 2) This analysis reflects general, nonfederal, acute care hospitals.
 - 3) AAMC COTH reflects members of the AAMC's Council of Teaching Hospitals and Health Systems, excluding those in Canada.

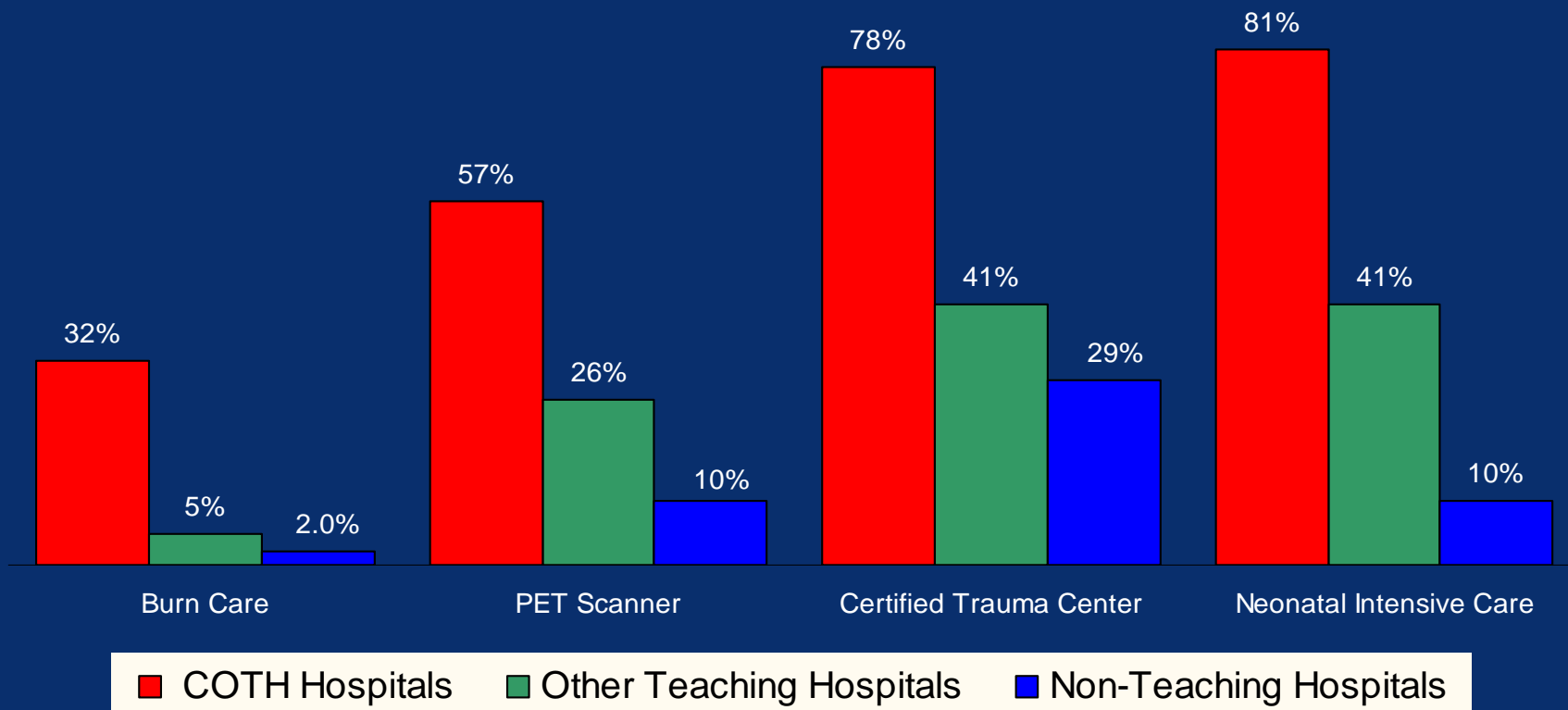
Comparison of Selected Community Services Provided by COTH, Other Teaching, and Non-Teaching Hospitals



Source: AAMC analysis of AHA Annual Survey Database, FY2003.

- Note:
- 1) Percentages equal the number of institutions that offer the selected service divided by the total number of institutions in the category.
 - 2) This analysis reflects general, nonfederal, acute care hospitals.
 - 3) AAMC COTH reflects members of the AAMC's Council of Teaching Hospitals and Health Systems, excluding those in Canada.

Sophisticated Clinical Services Offered by COTH, Other Teaching, and Non-Teaching Hospitals



Note: Percentages equal the number of institutions that offer the selected clinical service divided by the total number of institutions in the category.

Source: AAMC analysis of American Hospital Association FY 2003 data