



**Association of
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Jordan J. Cohen, M.D.
President

December 13, 2005

The Honorable Charles Grassley
Chairman
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Max Baucus
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Bill Thomas
Chairman
Committee on Ways and Means
U.S. House
Washington, D.C. 20515

The Honorable Charles Rangel
Ranking Member
Committee on Ways and Means
U.S. House
Washington, D.C. 20515

The Honorable Joe Barton
Chairman
Committee on Energy and Commerce
U.S. House
Washington, D.C. 20515

The Honorable John Dingell
Ranking Member
Committee on Energy and Commerce
U.S. House
Washington, D.C. 20515

Dear Committee Chairmen and Ranking Members:

The Association of American Medical Colleges (AAMC) appreciates the opportunity to share with you our views regarding the Medicare and Medicaid provisions included in the Senate and House-passed Deficit Reduction Act of 2005. As you know, the AAMC represents approximately 400 major teaching hospitals and health systems; all 126 accredited U.S. medical schools; 96 professional and academic societies; and the nation's medical students and residents. As you work to complete a final conference agreement, I respectfully request that you consider the following issues of concern to teaching hospitals and physicians, who provide a disproportionate share of healthcare services for Medicare, Medicaid and uninsured patients.

MEDICARE

Physician Payments: The AAMC represents the nearly 90,000 full-time clinical faculty members ("teaching physicians") who carry forth the patient care, education and research missions of the nation's medical schools and teaching hospitals. We are pleased that the

Senate bill provides temporary relief from the scheduled 4.4 percent cut to Calendar Year (CY) 2006 Medicare Physician Payments. However, we urge you to further improve upon the Senate proposal by providing two years of positive physician payment updates.

Also, since teaching physicians and teaching hospitals are inextricably linked in their commitment to serving Medicare beneficiaries, such physician payment relief should be achieved in a manner that continues to ensure adequate payments to hospitals. Last, I urge Congress and the Administration to commit to work together to develop a permanent solution to the problematic Sustainable Growth Rate (SGR) methodology.

Quality and Performance-Based Payments: The AAMC has been an active leader in the realm of quality, as evidenced by our founding membership in the Hospital Quality Alliance, as well as membership in the National Quality Forum, the AMA Physician Consortium for Performance Improvement, and the Ambulatory Quality Care Alliance. We appreciate that the Senate-passed legislation seeks to enhance the quality and value of Medicare services. However, the AAMC has a number of concerns and questions as to how the Senate “Value-Based Purchasing Program” will be implemented by the Secretary, who has broad authority under your proposal.

First, we have strong concerns with how the hospital quality pool is financed and are opposed to reductions in outlier funding. As you know, outlier payments help all hospitals recoup a portion of the costs for the care provided to the sickest and the most expensive patients. As tertiary care facilities, teaching hospitals serve a disproportionately large share of these patients. Even with these outlier payments, teaching hospitals experience substantial losses in caring for high cost patients. Reducing the outlier payment pool will dramatically raise the cost threshold (which determines whether a case is eligible for an outlier payment), thereby reducing the number of cases that qualify for these important payments. This outcome will only exacerbate the losses teaching hospitals incur in treating such cases.

Second, because the Senate legislation makes no fundamental change in the SGR formula, physician payment cuts will resume in CY 2007 and beyond. We remain concerned that the value-based purchasing proposal will magnify these already-substantial cuts, given that the physician quality payments are financed through additional reductions to the conversion factor beginning in CY 2009. Further, quality initiatives have been shown to result in increased volumes of certain services; under the current SGR system, any increases in volume will further erode payments to physicians.

Limited Service Hospitals: The AAMC supports retaining the Senate provision that permanently extends the moratorium on new physician-owned limited service hospitals. This will prevent full-service hospitals from experiencing the effects of inappropriate patient selection, reduced emergency room coverage, and other troubling and often anti-competitive behaviors that accompany physician ownership and referral of patients to those hospitals.

Medicare Rehabilitative Services: The AAMC is supportive of retaining the Senate provisions that will allow teaching hospitals to continue providing valuable rehabilitation services and urge you to retain these provisions.

MEDICAID

Overall, the AAMC believes that the Senate Medicaid package strives to assure the viability of the Medicaid program in a way that avoids shifting the cost of Medicaid services to beneficiaries, states, localities, and providers. The AAMC urges the conferees to reject House provisions that allow states to increase cost-sharing for beneficiaries and expand benefit flexibility. In addition, the AAMC urges the conferees to reject House provisions that would mandate rates between hospitals and managed care plans for services delivered to “out of network” beneficiaries.

Cost-Sharing/Benefit Flexibility: The AAMC is concerned by the House provisions that allow states to increase cost-sharing through new premiums and co-payments. As many Medicaid beneficiaries already struggle to pay the current allowable amounts, higher costs to beneficiaries could pose financial barriers to getting needed medical care. Similarly, the AAMC is concerned about benefit flexibility provisions that could lead to less coverage or reduced benefits for certain Medicaid populations. In either case, patients’ access to care could be compromised. Patients may defer treatment or wait until they are much sicker to seek treatment and may end up receiving care in a more costly setting, such as an emergency department. In this context, teaching hospitals and teaching physicians (who share a commitment to serving all patients, regardless of their ability to pay) would likely face a dramatically increased demand for uncompensated care from beneficiaries who lose coverage or benefits and can not access care elsewhere in the community.

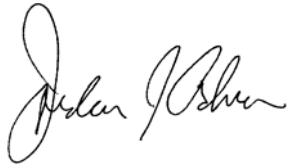
Rate Setting for Out of Network Care: The AAMC urges you to reject Sec. 3147 of the House Medicaid package that limits hospital payments for emergency services provided to "out-of-network" Medicaid managed care beneficiaries. Under the current House proposal, a provider “must accept as payment in full the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under [fee-for-service Medicaid].” The AAMC is concerned that this provision could jeopardize Medicaid Direct Graduate Medical Education and Indirect Medical Education payments that teaching hospitals have already negotiated with either Medicaid managed care plans or their state.

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Thank you for considering these issues of importance to teaching hospitals and teaching physicians. Certainly, the AAMC is sensitive to the budgetary constraints faced by Congress, and we support efforts to enhance the management, quality, and value of our nation’s healthcare programs. However, to assure that Congress achieves its goal in the most equitable, efficient, and effective manner, we encourage you to consider and

address the above concerns during conference negotiations. If you or your staff have questions, please contact Richard Knapp or Lynne Davis Boyle at 202-828-0410.

Sincerely,

A handwritten signature in black ink, appearing to read "Jordan J. Cohen". The signature is fluid and cursive, with the first name "Jordan" being the most prominent part.

Jordan J. Cohen, M.D.