April 19, 2010

Director,
Regulations Management (00REG1)
Department of Veterans Affairs
810 Vermont Avenue, NW
Room 1068
Washington, DC 20420
Submitted via http://www.regulations.gov

RE: RIN 2900-AN37, Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated with Non-VA Outpatient Care; Proposed Rule

Dear Sir or Madam:

The Association of American Medical Colleges (AAMC) is a not-for-profit association representing all 132 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 68 Department of Veterans Affairs (VA) medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. The AAMC welcomes this opportunity to comment on the proposed rule titled Payment for Inpatient and Outpatient Health Care Professional Services at Non-Departmental Facilities and Other Medical Charges Associated with Non-VA Outpatient Care (75 Fed Reg. 7216)

Many AAMC-member medical schools, teaching hospitals, and faculty practice plans have had long and fruitful relationships with the VA due to a shared commitment to patient care, research, and education. The VA has long looked to academic medical centers as sites where residents could be educated, and places where veterans would receive high quality services that are not available at VA facilities. As is true of every payer for health care services, the VA must be a prudent buyer. But this means that there should be a payment methodology that balances the VA’s need to constrain costs with providers’ needs to receive adequate payment for services.
Below are the AAMC’s comments on the specific issues in the proposed rule.

**Negotiated and Fee Schedule Rates: Preserving the Principles of Directive 1663**

The preamble states that:

Accordingly, in proposed paragraph (a) (2) (i) and (a) (2) (ii), we added a clarifying amendment to specify that negotiating such agreements is the preferred method for determining payment amounts for all non-VA physician and other health care professional services *only if* such amount is lesser than would be payable under the applicable Medicare or VA Fee Schedule rate and billed charge. (p. 7219; emphasis added)

However, the proposed regulatory language seems to indicate that the “lesser of” methodology applies only when the payment rate has *not* been negotiated, and makes no reference to a requirement that the negotiated amount be less than a fee schedule amount. It says that:

For inpatient and outpatient health care professional services, and all other medical services associated with non-VA outpatient care, using the applicable method in this section:

1. The amount negotiated by VA and the provider under the Federal Acquisition Regulation (FAR) . . .
2. If an amount has not been negotiated under paragraph (a)(1), VA will use the lesser of the following: (p. 7226)

The AAMC requests that the VA clarify whether the preamble language or the regulatory language correctly states VA policy. If it is the preamble language, is it the VA’s intention that any negotiated rate must be less than the Medicare or VA fee schedules? Teaching hospitals, medical schools, and faculty practice plans often negotiate payment rates with the VA, and the rates may exceed those of either the Medicare or VA Fee Schedule. For example, they may contract with the VA under Directive 1663 as sole source providers. That directive states that “contract cost cannot be the sole consideration in the decision on whether to sole source or to compete.” ((Directive 1663, 4.a. (2) (a)). It goes on to say:

The decision to compete contracts for services that overlap programs in which the facility has graduate medical education training in place must be weighted by additional factors beyond the contract costs. The decision must consider all implications to the business, including the impact to the facility’s training program, which is a direct contributor to the facility’s productivity and may provide offsets. (Directive 1663, 4.a. (2) (b)
The AAMC believes it is important that VA regulations continue to preserve the principles in Directive 1663, *Health Care Resources Contracting-Buying*. If teaching institutions must accept fee schedule rates or lower, they may choose to no longer contract with the VA, thus reducing veterans’ access to care.

**Fee Schedule Rates Should Include Adjustments**

The proposed rule says that the VA “would not authorize additional payments or any payment adjustments greater than the amount specified in the published Medicare fee schedule and prospective payment system, such as end-of-year settlements or other periodic adjustments made by Medicare . . .” (p. 7220). The proposed rule indicates that this includes “costs of direct medical education.” The Medicare program recognizes that teaching hospitals have higher costs as a result of teaching residents and the specialized services they provide. Consequently, Medicare makes two additional payments to teaching hospitals: the direct GME payment recognizes the costs of educating residents, while the indirect medical education (IME) payment is for the higher patient care costs incurred.

We acknowledge that the VA incurs costs for residents’ stipends and benefits, which are included in the Medicare, direct GME payment; however, this payment also reflects other direct costs, such as overhead and GME activities that occur in the hospital. There are many costs related to providing patient care in a teaching hospital setting that are not covered. VA patients benefit from being in a teaching setting, especially when they are sent there to receive care that is not available elsewhere. The VA should be willing to pay its share of the additional costs associated with teaching hospitals. At a minimum, the VA should include the IME payment add-on to the DRG rates. The AAMC would be pleased to work with the VA to identify a methodology for paying for these additional costs.

The VA also should pay appropriate geographic adjustments to the fee schedule, just as Medicare does.

**Transitioning to a New Methodology over Several Years**

The VA estimates that over five years if will save over $1.5 billion and acknowledges that “this proposed rule will economically impact the health care community.” (p.7219) If the VA finalizes this rule, the AAMC strongly supports using at least a 4 year transition period, as often is done by the Medicare program. This will give providers the opportunity to attempt to adjust to reduced payment rates and may help to lessen the impact on veterans’ access to care should some providers decide that they can no longer treat veterans.
Other Issues

The AAMC also requests that the VA clarify whether the proposed rule would affect payment rates during the time that a contract expires and the VA wants to either extend the contract temporarily or use an interim contract. If so, please provide additional information.

While the proposed rule mentions the VA fee schedule, it is unclear where this is posted or how it is developed. The AAMC asks that the VA make the fee schedule and the methodology underlying it available to the public on its website.

The AAMC also asks that the VA clarify the term “repricing agent” which the rule proposes will replace the term “physician’s agent.” Is this term meant to indicate the person or entity that negotiates on behalf of a physician? For example, a faculty physician would expect to provide services to the VA under a contract that is negotiated by an individual who represents the practice plan of which the physician is a part. Since neither the term “physician’s agent” nor “repricing agent” is commonly used, a clear definition of the term that is incorporated into the final rule should be provided.

If you have any questions, please contact Ivy Baer, Director and Regulatory Counsel, at ibaer@aamc.org or 202-828-0499.

Sincerely,

Joanne Conroy, M.D.
Chief Health Care Officer