July 7, 2010

Via Electronic Mail

Chairman Glenn Hackbarth, J.D.
Medicare Payment Advisory Commission
(MedPAC or the Commission)
601 New Jersey Avenue, N.W.
Suite 9000
Washington, D.C. 20001

Dear Chairman Hackbarth:

On behalf of the Association of American Medical Colleges (AAMC), I write to respond to the recommendations that the Commission made regarding graduate medical education (GME) in your recent June Report to the Congress, released on June 15. The AAMC is a not-for-profit association representing all 133 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 nearly 128,000 clinical faculty members, 75,000 medical students, and 110,000 resident physicians.

The AAMC appreciates the time and effort MedPAC spent over the last two years to study the GME process and Medicare’s role in helping to financially support the additional costs of training and associated missions of teaching hospitals. However, we are very disappointed that MedPAC chose to ignore the immediate need for an increase to the current Medicare resident caps to address the health care needs of an aging and growing population, instead recommending only that the Secretary of Health and Human Services (HHS) conduct another study of workforce issues. As recently as December 2008, the Health Resources and Services Administration projected a shortage of over 50,000 physicians within the next decade. As an additional 32 million Americans gain health insurance and 36 million “baby boomers” enter the Medicare program with increased needs for services, the U.S. needs to train more physicians. Lifting the caps is central to that outcome. Future delivery reforms may decrease the shortage of physicians in some areas, but such reforms will not overcome the overall shortage and especially will not do so in time to address near-term access problems.

We oppose the Commission’s recommendation to reduce indirect medical education (IME) payments by more than 50 percent and put them “at risk” in a performance-based incentive program. We believe such action is unnecessary given the accreditation standards already in place, and because it would significantly destabilize the academic medical community.

Medicare provides critical support to teaching hospitals through two payments. The direct graduate medical education (DGME) payment helps offset a fraction of the direct educational costs associated with training residents, which include resident stipends and benefits, supervising faculty costs, and related costs associated with managing the GME enterprise. The IME payment
recognizes the higher patient care costs at teaching hospitals, associated in part with treating a complex patient population and providing a clinical environment in which education and research can flourish. Though they share the “education” label, IME payments are intended to support the costs of patient care.

We are pleased MedPAC recognizes that teaching hospitals and medical schools produce “superbly skilled clinicians while contributing to stunning advances in medical science.” We also agree that medical education and graduate training need to be aligned with delivery system reforms to ensure future physicians are prepared to practice and lead in high quality, cost effective environments. AAMC member teaching hospitals and medical schools already incorporate the desired initiatives into their residency training curricula. In part this is to prepare residents in the “core competencies” required by the Accreditation Council for GME (ACGME), the body that accredits residency programs and their sponsoring institutions. The core competencies mirror the goals MedPAC is advocating.1 Teaching hospitals and medical schools also are implementing these initiatives because they recognize the need for delivery system changes and their corresponding role in ensuring that future physicians have the skills and experiences to lead and practice in such reformed systems.

While we appreciate that, unlike in past years, MedPAC did not recommend an absolute cut in IME payments, we oppose the suggestion that Congress reduce IME payments by more than 50 percent, about $3.5 billion, to establish a “performance-based incentive program.” Placing these payments at risk would destabilize, and potentially devastate, the training and clinical care activities in communities, particularly at a time when teaching hospitals and medical schools are expending additional resources to implement the initiatives that MedPAC advocates. Even at the current level of IME funding, MedPAC analyses show that the aggregate overall Medicare margin for major teaching hospitals was -1.5 percent in 2008 (March 2010 Report). Medicare also is underfunding teaching hospitals currently because of the resident cap imposed by the Balanced Budget Act of 1997 and a DGME payment formula that results in payments less than Medicare’s share of actual direct educational costs. For further information about these and other issues I refer you to the letter we sent to the Commission on February 17, 2010.

To the extent any external impetus is needed to further educational changes in GME curricula, we believe the appropriate body is the ACGME, not HHS. The ACGME has the educational expertise and continually works to improve residents’ performance in the core competencies, developing milestones of performance for residents in each specialty and emphasizing experience in interdisciplinary teams in the new common program requirements that were issued June 23, 2010.

1 These include, but are not limited to, demonstrated competence in: systems-based practice; quality and patient safety; use of information technology; and delivering care in interprofessional teams.
We strongly support the Commission’s recommendation that the Secretary study strategies to increase the diversity of the health professional workforce, as it is consistent with the AAMC’s longstanding commitment to increase diversity in medical education and advance health care equity in the United States. The AAMC continues its initiatives to develop a diverse, culturally competent medical workforce, though challenges remain at each stage of the pipeline.

We have great respect for the Commission and its work. We particularly appreciate the attention MedPAC has given to new payment and delivery models. We are very supportive of these efforts as demonstrated, in part, by the work the AAMC has done to develop the concept of the healthcare innovation zone (HIZ). The HIZ is one of the pilot programs that the Center for Medicare and Medicaid Innovation is legislated to test. An HIZ will be built around the core of an academic medical center (AMC) and will test delivery and financing system changes for a large population of patients. The education and research environments of AMCs will accelerate the translation and sharing of knowledge to the entire health care system.

Our members are very interested in pursuing delivery model changes, but we must recognize that these are ambitious endeavors that will require significant modifications to the current system. Putting 50 percent of IME payments at risk would result in a destabilization that could jeopardize the success of these initiatives. Now is the time to support institutions that seek to promote true payment and delivery reforms and maintaining IME funding levels is a critical component of that support.

Sincerely,

Darrell G. Kirch, MD

cc: Mark Miller, Ph.D., MedPAC Executive Director
    Karen Fisher, J.D., AAMC Senior Director and Senior Policy Counsel
    Atul Grover, M.D, Ph.D., AAMC Chief Advocacy Officer