January 26, 1999

National Bipartisan Commission on the Future of Medicare
101 Independence Avenue, SE
Washington, DC 20540-1998

The American College of Physicians-American Society of Internal Medicine, with over 110,000 members, is concerned about the Bipartisan Commission's recommendations about graduate medical education (GME). Among our members are tens of thousands of teaching physicians, residents, and administrators at teaching hospitals, clinics and other training sites providing graduate medical education throughout the nation, We are alarmed by recent indications that the Commission may recommend removing GME-related payments from the Medicare program and making them subject to the annual appropriations process. This recommendation would jeopardize the adequacy and the stability of federal funding for graduate medical education (GME). We urge you not to make this recommendation.

The framers of Medicare recognized that all of society, including Medicare beneficiaries, benefits from having well-trained physicians and healthy teaching hospitals and clinics. These institutions train our doctors and they do most of the research that produces and evaluates the innovations that will someday improve health while simultaneously reducing the costs of health care. The Medicare framers recognized that the Medicare program, as well as other health care payers, should provide financial support to assure the continued high quality of the institutions and programs that provide the environment of education, training, and research needed to prepare our future physician workforce. The Medicare program has long recognized that payments for patient care services provided to Medicare beneficiaries by physicians in training must reflect the direct costs of GME (DME) and that additional payments are required to compensate hospitals that provide a disproportionate share of care for low-income, indigent, and otherwise medically under-served patients (DSH).

Medicare is now the largest single source of funding for graduate medical education. It provides a stable source of funding for the culmination of an educational process that involves four years of college, four years of medical school and three to seven years of residency and fellowship training. Irreparable harm to the educational process could result from replacing this stable source of funding for residency education and training with a process that would be subject to political pressures and the vagaries of the appropriations process. As we shall show, the funding for teaching hospitals is already shrinking, due to federal legislation and the competitive marketplace.

1. GME is an important source of funding for these hospitals. It enables them to compete in a very tough healthcare market. Without it, they could not support the costs of training in primary care, which is very costly.

2. With the amount appropriated for GME varying, the hospitals' income would fluctuate unpredictably from year to year, making it much more difficult to plan and to invest in improvements that would be good for patients and for clinical research.

3. Aside from unpredictability, placing GME in the appropriations process would lead to less and less GME funding, as Congress reacts to the rising cost of Medicare.

In adopting the Balanced Budget Act of 1997 (BBA), Congress authorized a series of substantial changes that will curtail Medicare funding for GME. The most important of these changes reduces Medicare adjustments for indirect medical education expenses (IME) from the 1997 level of 7.7% for every 10 percent increment in a hospital's resident-to-beds ratio to 7.0% in FY 1998; 6.5% in FY 1999, 6.0% in FY 2000 and 5.5% in 2001 and thereafter. Effective October 1, 1997, Medicare capped the number of full-time equivalent residents that it would support. Reimbursements for costs of both the DME and IME henceforward are based on the counts reported by the hospital for the period ending December 31, 1996. The full impact of these measures is yet unknown.

The BBA "carved out" DME and IME components from Medicare capitated payments to risk management plans and directed that such payments be paid directly to teaching hospitals for the care of patients enrolled in managed care plans. However, these GME payments will be phased-in over 5 years. Hospitals will be paid only 20% of DME and IME amounts for managed care patients in 1998, 40% in 1999, 60% in 2000, 80% in 2001, and 100% in 2002 and thereafter.

New Medicare payments limits on hospital overhead and supervisory physician costs will also be phased-in over five years. In addition, the legislation authorized demonstration projects similar to the one in New York that would encourage voluntary reductions in the number of residents.

The effects of all these changes, which have not yet even been fully implemented, can be expected to significantly reduce Medicare funding for GME. Meanwhile, other health care payers in an increasingly competitive health care marketplace demand acceptance of lower payment rates and direct many patients away from teaching hospitals to lower cost settings. These changes in Medicare support of GME and reduced payments from private sector payers imperil one of our country's most important treasures, its medical teaching institutions.

We firmly believe that the ultimate solution to achieve adequate and stable funding for GME will be to develop a health care system in which all payers contribute their fair share. We strongly commend this solution to the Commission's attention. However, at present, the impact of recent budgetary reductions is yet to be fully determined and there is no plan for improving funding participation by other payers. These considerations convince us that it would be extremely dangerous at this point to further destabilize Medicare funding for GME by making it subject to the budget appropriations process.

Sincerely,

Harold C. Sox, MD, FACP