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Also sent to each member of the Medicare Payment Advisory Commission (MedPAC)

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The undersigned physician organizations have followed the Medicare Payment Advisory Commission's (MedPAC) deliberations on graduate medical education very closely. We continue to have significant concerns about MedPAC's approach and urge you and other Commissioners to defer further action until additional impact studies can be completed. **Specifically, we believe that the Commission should examine the impact of its proposal on residency training, not just on the financial implications for hospitals that provide that training.**

We appreciate the many hours the Commission has spent in examining the role that Medicare has and should play in the funding of graduate medical education. We have anxiously awaited the simulations staff presented on the proposal's financial impact on hospitals. However, we now find that those simulations have increased, rather than alleviated, our concerns with MedPAC's proposal.

It is our understanding that two of the three options under consideration would remove some \$1.5 billion from Medicare's GME payments and then either redistribute the money to all hospitals or return it to the federal treasury. Under any of the three options, more than half the nation's teaching hospitals would see a reduction in Medicare funding. Depending on the option involved, many highly-regarded programs would see their funding for graduate medical education drop by 5% or more.

At a time when teaching hospitals' total margins are the lowest of any major hospital group, such cuts would threaten the very existence of some institutions and even those that survive could be forced to reduce or modify their residency training programs. At the very least, these changes are likely to prove extremely disruptive for hospitals, medical schools, and physicians-in-training. More important, without some national strategy to govern the size and shape of these changes, over time they could jeopardize the continued availability of adequate numbers of well-trained physicians in some essential specialties.

The Commission has argued that these workforce issues should be dealt with through discretionary grant programs subject to the whims of the federal budget process. We respectfully disagree. These discretionary grant programs are a small and shrinking part of the federal budget. They will never adequately compensate for reductions in Medicare-funded training programs. They can never provide the stability and commitment needed to ensure that once an individual enters a residency, the position can be maintained for the full number of years required for certification in a chosen specialty.

Congress clearly wanted MedPAC to consider workforce issues as part of its GME recommendations. The Balanced Budget Act of 1997 (BBA) called for recommendations in several specific areas, including: funding for international medical graduates; "methods for promoting an appropriate number, mix and geographical distribution of health professionals;" and issues regarding

children's hospitals and pediatric training programs. The Balanced Budget Refinement Act (BBRA) enacted just last year directed the Commission to do two more GME studies. Both are workforce-related.

Given these mandates, Congress obviously will want to know the impact of any MedPAC proposals on physician workforce. What little information Commissioners have received to date suggests that there is reason for concern. We note, for example, that when the Commission first began to discuss its current GME proposal a year ago, a number of alarming ramifications were raised during a staff presentation on the plan's potential impact. One possibility is that hospitals will eliminate needed primary care residencies because they do not generate significant revenues for the facility. Others include probable reductions in hospitals' training infrastructure; and disincentives to provide training in ambulatory care and rural settings.

Since the Commission would not initially include outpatient training in its proposal, some of the problems raised a year ago may not occur immediately. However, the maintenance of two different payment systems for inpatient and outpatient training could prove to be a burden in and of itself. Moreover, even the implication that the proposal will be eventually be extended to outpatient settings could prove counterproductive to efforts to expand training outside the hospital.

It appears then that all of the questions raised about the proposal a year ago still are relevant. **Yet to date, the Commission has not been provided with enough information to determine the extent of these problems or their likely impact on the numbers and mix of physicians available to treat Medicare beneficiaries.**

In addition, we believe that the Commission should carefully delineate the problems that need to be addressed in the current system, determine whether its proposal would actually resolve those problems, and consider whether there are less disruptive ways of achieving the same goals. The BBA and the BBRA took steps to limit the number of Medicare-funded residencies and to reduce hospital-to-hospital variation in direct medical education payments per resident. How do we know that additional changes are needed until these reforms have had time to take effect? What additional problems does MedPAC want to address and what is the likelihood that its proposal would do so more effectively than a more incremental approach?

Should you conclude after this more rigorous examination that the Commission is on the right track with its proposal, additional clarifications will be needed. Since the Commission's plan would continue to use a residents-to-beds ratio to determine the size of payment adjustments, it is more accurate to refer to a "teaching adjustment" than an "enhanced patient care adjustment." Consequently, we believe the Commission should acknowledge that its proposal bases payment on teaching load and abandon any further discussion of the unquantifiable concept of enhanced patient care. **We would also urge the Commission to include medical training in the discussion of services that justify higher payments to teaching hospitals.**

The groups we represent are not opposed to changes in the funding of graduate medical education. Nor do we believe that Medicare should bear the burden alone. In fact, we have advocated a number of changes, including the creation of an all-payer fund that would require other payers to contribute to the cost of training physicians.

As physicians, our members operate under a creed of "first do no harm." Before proceeding with any treatment, they must first ask themselves "Is this good medicine?" **We are not yet convinced that MedPAC's proposal would not do harm and are therefore urging you to conduct additional studies to determine whether this really is the right medicine before moving beyond the conceptual framework you provided Congress last August.** The medical profession values this opportunity to express our views and would be pleased to assist you in further analysis of your proposal.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngology - Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association for Thoracic Surgery
American Association of Clinical Endocrinologists
American Association of Orthopaedic Surgeons
American Association of Neurological Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Osteopathic Family Physicians
American College of Physicians-American Society of Internal Medicine
American College of Osteopathic Surgeons
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American Gastroenterological Association
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