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President and Chief Executive Officer

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The Honorable Max Baucus
Chair, Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Baucus:

The United States health care system faces a crisis of access, cost, and quality that must be addressed now. The Association of American Medical Colleges (AAMC) and our members share your commitment to achieving meaningful health reform this year, and we stand ready to work with you to implement solutions that will strengthen the health of our nation.

In that light, we wish to reiterate our positions on key health care reform proposals considered by Congress over the last few months, particularly as they relate to the issues of greatest importance to the nation's medical schools and teaching hospitals. We also wish to reiterate our support for a new delivery model (the "Health Care Innovation Zone") to help test the effectiveness and feasibility of various health care reform proposals in a way that neither penalizes innovation nor threatens the essential core of our health care system: patient care, clinical education, and medical research.

Background

The mission of the AAMC is to serve and lead our members—the nation's medical schools and teaching hospitals—to improve the health of all. The AAMC represents all 130 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic scientific societies. Through these institutions and organizations, the AAMC represents 109,000 clinical faculty members, 75,000 medical students, and 106,000 resident physicians. Our members play a significant role in the country's health care system by educating and training our future physicians and providing sites for clinical education of other health professionals.

These institutions and individuals also care for a disproportionately large number of uninsured individuals, as well as people in need of specialized services unavailable elsewhere in their communities. Major teaching hospitals (in collaboration with various clinical providers, including medical school faculty) account for 6 percent of all acute care hospitals, yet provide 40 percent of all hospital charity care and 26 percent of Medicaid inpatient care.

Additionally, the National Institutes of Health (NIH) recognizes the AAMC membership's unique capacity and commitment to advancing scientific knowledge alongside education and clinical care by investing nearly half of its annual budget in support of research conducted at medical schools and teaching hospitals.

AAMC Recommendations

The AAMC offers the following priority recommendations essential to reform of our nation's health care system:

1. Preserve the Safety Net

Existing programs that serve uninsured and underinsured populations should be maintained until we are able to fully demonstrate the effectiveness of alternative approaches. The AAMC recognizes and supports the need for change in the overall health care financing and delivery structure. We also recognize that implementing new programs and structures will take time. Consequently, we believe that current programs should be supported until we are certain that the replacements offer indisputable improvements over current programs.

The AAMC recognizes and endorses health care reform that would provide health insurance coverage to all, but it would be premature to consider reducing or redirecting Medicare and Medicaid disproportionate share hospital (DSH) payments before we know if any expansion of health care coverage is working. As coverage expansion occurs, it is also important to remember that there will be individuals who, for a variety of reasons, will still not obtain coverage but will seek treatment by health care providers.

Additionally, it is important to keep in mind that Medicare and Medicaid DSH payments are intended to address significant gaps between the actual costs of care and the reimbursement for such services. This is particularly true for Medicaid reimbursement levels, which typically fall significantly below the actual cost of providing such services. Hospitals that continue to treat a disproportionately large number of Medicare and Medicaid patients will need additional ongoing financial support to fill such gaps.

If expanded coverage reimburses providers at rates below the costs of delivering care, financial support will still be needed to ensure that necessary services provided to all patients can be maintained. **Because there remain many unknowns, we strongly urge you to keep current safety net mechanisms in place until the new or expanded programs can be evaluated.**

2. Develop the Workforce

The AAMC and its members are committed to training a health care workforce that helps facilitate improvements in the health care system while improving the health of communities.

The supply of well trained health professionals must reflect our population and its health care needs and have the capacity to provide the right care at the right time. Because the education and training of a physician may require a decade or more, the nation must start investing today in the growth of the physician workforce while it concurrently works to improve the delivery system and achieve a better balance between the health workforce and the needs of the population. Without an immediate

workforce expansion, access problems for all individuals (particularly for those in underserved communities), will be exacerbated.

We strongly support lifting the Medicare resident caps. Since 1998, Medicare has "capped" the number of residents for which the program would provide support for the associated training costs. Achieving an increase in the physician supply requires a lifting of these caps, as well as an increase in medical school enrollment. Under the recently introduced "Resident Physician Shortage Reduction Act of 2009" (S. 973/H.R. 2251), America's health care infrastructure will be strengthened by expanding by 15 percent the number of Medicare-supported physician training positions. Preference will be given to expanding programs that train primary care physicians and general surgeons. The bill also changes existing Medicare regulations that are troublesome barriers to training residents in non-hospital settings. Finally, S. 973/H.R. 2251 strives to assure that Medicare-supported training slots from closed teaching hospitals are redistributed among other nearby teaching hospitals.

Whether or not Congress agrees to lift the Medicare "caps," the AAMC urges you to maintain current Medicare and Medicaid support for their share of the costs of direct graduate medical education (DGME) expenses and indirect medical education (IME). Given these times of increasing financial uncertainty for teaching hospitals, it is important that Medicare and Medicaid maintain their commitment since 1965 to support the additional costs associated with the educational, research, and patient care missions of our member institutions. **It is particularly important that the IME adjustment be maintained at its current level to support the higher costs of care in teaching hospitals and to help teaching hospitals maintain an environment in which training, innovation, and the highest levels of clinical care can flourish together.** Not doing so would destabilize the institutions upon which Medicare beneficiaries and all patients depend.

3. Repeal Medicare's Sustainable Growth Rate (SGR)

Adequate Medicare reimbursement for physician services is vital to sustaining the missions of the nation's medical schools. On average, the patient care revenues generated by medical school faculty members accounts for more than one-third of medical school funding. Medicare represents one-quarter of that clinical revenue.

The current formula used to calculate Medicare physician payments will produce a 21 percent reduction effective January 1, 2010, along with negative updates for the next several years. Without reliable and adequate physician payments for Medicare services, the ability to provide such services may be jeopardized and adversely affect Medicare beneficiaries' access to care.

The AAMC supports replacing the Sustainable Growth Rate (SGR) formula with a payment system that, at a minimum, adequately compensates physicians based on such factors as the services provided, complexity of the patients served, and geographic area where the physician practices, while also accounting for increased costs due to inflation.

4. Improve the Delivery of Health

The health care delivery system must be restructured to facilitate health promotion and disease prevention while providing high-quality, cost-effective diagnosis, and treatment of illness as well as palliative care. The current delivery system is disjointed and lacks the necessary infrastructure and processes to achieve optimal results. An improved delivery system should help engage professionals to provide coordinated patient-centered care by improving communication among providers and patients. The AAMC has consistently partnered with others in the hospital community to improve the quality and safety of patient care. **We strongly support the concept of aligning payment with the delivery of high-quality patient care, but given the complexity and magnitude of such an approach, we recommend moving forward cautiously, thoughtfully, and deliberately.**

The AAMC supports an incremental implementation of the Value-Based Purchasing (VBP) program, it should, reward both quality improvement and quality attainment. We recommend that no more than 1 percent of hospital payments be used to reward performance, given that the approach is untested and unproven. Given the successful experience of the hospital quality reporting program, we believe that a 1 percent maximum level is sufficient to incentivize hospitals. All hospitals should be eligible and have equal opportunities to receive incentive payments. The AAMC believes that any VBP program should align incentives across all provider groups in a way that encourages broad and unified efforts to improve patient care.

While the AAMC agrees that current payment systems lack incentives for coordinating services across the continuum of care, we strongly recommend permitting the health care community to conduct careful analyses and modeling before moving forward. Hospital readmissions are complex, system-wide occurrences that involve multiple caregivers. We agree that to the extent a readmission policy is implemented, it should be a temporary solution; additional deliberation of coordinated policies is still needed to achieve high value care. Public polices seeking to reduce readmissions should focus exclusively on certain types of unplanned readmissions that are related to the initial admission, and where there are evidence-based approaches or actions that hospitals can take to prevent the occurrence of the readmission. **The AAMC also strongly believes that readmission rates should, in some manner, account for the socio-economic status of patients, and/or whether they are dually eligible for Medicare and Medicaid. Failing to recognize the higher readmission rates for such patients unfairly penalizes teaching hospitals and other safety net institutions that serve disproportionately large numbers of low-income-patients**.

The AAMC believes that, conceptually, payment bundling has the potential to improve care coordination. However, the concept must be more fully tested (e.g. voluntary demonstration projects) and defined before being fully implemented. The current Acute Care Episode Demonstration Project is too limited to provide the necessary information to ensure success of such a program nationwide. **Moreover, it is important that any payment bundling encompass all aspects of care provided**

during the episode and that equitable payments are made to the various providers (e.g. physicians) whose services comprise the bundle.

Moreover, we urge you to look beyond the relatively unsubstantiated rhetoric proclaiming that 30 percent of health care is waste. While evidence suggests that some areas of the country consume greater Medicare resources than others, we still do not know what drives such variation. In fact, the discrepancies revealed by the Dartmouth Atlas raise more questions than they answer. For example, do trends in Medicare spending accurately serve as a proxy for overall health care spending? Are variations reflective of racial and socioeconomic differences? They should also reflect health care spending outside of Medicare. Certainly questions surrounding "variations" should be answered, but to base policy decisions solely on spending discrepancies may produce disastrous unintended consequences.

5. Support Broad Innovation in Delivery Models

Many American's feel "medically homeless" in a health care system that is difficult for patients to navigate when they need care or advice. Patients and providers alike are deeply dissatisfied with the current delivery system. New models of care delivery must be developed, focusing on patients and their problems while improving delivery and outcomes.

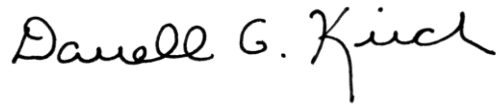
The AAMC proposes the creation and testing of a concept called the "Health Care Innovation Zone" (HIZ). An HIZ is an integrated delivery network and partnering organizations encompassing the full spectrum of comprehensive and community care, organized around a centralized system that includes an academic medical center (e.g., maintains multiple missions of patient care, medical education, and scientific research). Our goal is to build upon the accountable care organization (ACO) and medical home concepts developed by others (e.g. MedPAC and Brookings), and to test it using our member institutions and their partners, with the ultimate goal of enhancing clinical practice to improve the health of our nation.

With the development of new models of care, the AAMC believes greater investment is needed in the research necessary to better understand how to measure the core functions of a coordination of care concept and to develop an evidence base for how the model is best implemented. Payment for the new model should appropriately recognize and reward health care providers for their contributions to prevention, patient care, and care coordination.

Conclusion
The AAMC and its members are committed to working with you, and we believe that academic medicine must play a pivotal role in improving health and health care and in achieving positive changes in the health care system. With a concerted national effort from both the private and public sectors, the goal of affordable, quality health care for all is achievable. The AAMC also has a set of principles that our community believes should guide health care reform discussions. These principles for U.S. Health Care Reform: A Guide for Policy Makers is available at: https://services.aamc.org/Publications/showfile.cfm?file=version121.pdf&prd_id=243&prv_id=298&pdf_id=121.

The AAMC appreciates your commitment to achieving comprehensive health care reform benefiting all Americans. We look forward to working with you to strengthen our nation's system of medical education and ensuring that safe, quality care is provided to all who require it.

Sincerely,



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