Statement

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On

The Administration's Regulatory Actions on Medicaid:
The Effects on Patients, Doctors, Hospitals, and States

Presented to the

The Committee on Oversight and Government Reform
United State House of Representatives

By

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Good morning, Mr. Chairman and Members of the Committee. I am Dr. Sheldon M. Retchin, Chief Executive Officer of the Virginia Commonwealth University (VCU) Health System. I also am Vice President for Health Sciences at VCU in Richmond, Virginia.

The VCU School of Medicine, and its teaching hospital, MCV Hospitals, is a long-standing member of the Association of American Medical Colleges (AAMC), which represents almost 400 major teaching hospitals and health systems, 126 accredited U.S. medical schools, and 94 academic and professional societies. Through these institutions and organizations, the AAMC represents 109,000 faculty members, 67,000 medical students, and 104,000 resident physicians.

The VCU Health System includes MCV Hospitals, with 779 licensed beds; MCV Physicians -- a 600-physician-faculty group practice; and Virginia Premier, a Medicaid Health Maintenance Organization with 110,000 enrollees from across the Commonwealth of Virginia. The VCU Health System has the region's only Level 1 Trauma Center, is one of only 2 burn centers in the entire state, and its Massey Cancer Center was the first cancer center in Virginia designated by the National Cancer Institute more than 30 years ago. It offers state-of-the-art care in more than 200 specialty areas, many of national and international note, including organ transplantation, head and spinal cord trauma, burn healing and cancer treatment. The VCU Medical Center includes the Schools of Medicine, Allied Health, Dentistry, Pharmacy and Nursing, as well as a School of Public Health planned for 2010. We have more than 4000 students on our medical center campus who are being educated as pharmacists, dentists, dental hygienists, doctors, nurses, and physical therapists, to name but a few of the training programs. We have 650 post-graduate trainees in medical and surgical specialties across the full spectrum of care. Our students and post-graduates form the backbone of the health care workforce of Virginia, and many move on to other states across the country.

I am honored to testify before the committee about the detrimental impact of the recent CMS Medicaid regulatory actions, and particularly its proposed rule to eliminate federal matching payments for graduate medical education (GME) made under the Medicaid program. I, and indeed the entire teaching hospital community, greatly appreciated Congressional passage of the one-year moratorium preventing any regulatory action on this rule until May 2008. We also are grateful to Reps. Eliot Engel (D-NY), Sue Myrick (R-NC), and over 110 bipartisan cosponsors for advocating in support of the "Public and Teaching Hospital Preservation Act" (HR 3533) to extend the moratorium for an additional year. However, I hope today's testimony demonstrates that the Medicaid GME proposed rule would severely, and perhaps irrevocably, compromise the unique missions of teaching hospitals, with the result that Congress will act quickly to prevent promulgation and implementation of this short-sighted policy.

Teaching Hospitals and Medical Schools are Major Healthcare Providers for Medicaid Beneficiaries

Teaching hospitals, medical schools, and their clinical faculties historically have served as fundamental components of the nation's health care safety net. While representing just 20 percent of the nation's hospitals, teaching hospitals account for 42 percent of all Medicaid discharges. In fact, Medicaid represents 17 percent of the healthcare services provided by medical school faculty compared to 9 percent of services provided to Medicaid patients by private, community-based multispecialty physician groups. Nationwide, 51 percent of newborns are delivered at teaching hospitals—many covered by Medicaid. Among medical school faculty practices, 27 percent of obstetric services and about 40 percent of pediatric care is provided to Medicaid patients. Obstetrics and pediatrics are two specialties where there are particular physician workforce shortages in our state.

At Virginia Commonwealth University we are, by a wide margin, the largest Medicaid provider in the region. At our institution Medicaid beneficiaries represented approximately 8,400 discharges last year, or 26% of all discharges from our medical center. In addition to the inpatient services provided, Medicaid recipients also accounted for approximately 15,600 (or 26%) of the 60,000 Emergency Department visits that did not result in an admission. This population also had 65,000 outpatient visits, or approximately 16% of the total outpatient volume for our institution. Like many other inner city academic medical centers, the 1,633 Medicaid deliveries that occurred at VCU Health System last year represented a disproportionate number (over 63%) of the total deliveries in our institution. Unfortunately, this was also the case for admissions to the Neonatal Intensive Care Unit. In 2007, approximately 65% of babies discharged from the NICU were Medicaid beneficiaries; in 2006, Medicaid babies represented 70% of the discharges from the unit. There are multiple factors that influence negative birth outcomes and the support provided through the combination of patient care, education, research and ingenuity through the academic affiliations of medical centers who care for this population would be severely impacted if funding is depleted in the future.

In addition to the Medicaid population, the VCU Health System provides a significant amount of care for low income, or indigent patients. The indigent patients, who are primarily working adults who do not qualify for Medicaid, accounted for approximately 4,800 (or 15%) discharges and over 15,000 (or 25%) emergency department visits. In addition, the indigent population represented approximately 26% of the outpatient volume in our institution. These numbers, combined with the services to Medicaid populations, represent a significant amount of the health care provided by our facilities. These numbers are unrivaled by other hospitals in our area – making the future of the academic medical center tenuous at best in geographic regions that are experiencing increases in the ranks of the uninsured.

Thus, for major teaching hospitals like MCV Hospitals, Medicaid payments represent a significant segment of their total revenue. Any Medicaid cuts, and

particularly those of the magnitude proposed, will directly affect the fiscal condition of major teaching hospitals and could threaten their ability to maintain services offered to Medicaid and other patients, including many services that few other hospitals provide. For example, in 2005 major teaching hospitals provided nearly one-half of all hospital charity care. These institutions maintain one-half of all pediatric intensive care beds and nearly one-third of all intensive care beds for premature/seriously ill newborns. The nation's teaching hospitals were among the first to offer comprehensive care for AIDS patients, whom often rely on Medicaid for their health coverage. Most recently, teaching hospitals are looked to as front-line responders, with stand-by capacity, in the event of a biological, chemical, or nuclear disaster. At VCU, we have devoted significant resources to fulfilling that role.

Nearly 90 percent of major teaching hospitals offer emergency psychiatric service compared to just 25 percent of non-teaching hospitals. At VCU, our own teaching hospital and medical school maintain the area's most comprehensive psychiatric treatment center for children and adolescents. This past year we had 2600 outpatient visits and had 440 admissions for behavioral health problems; 90 percent of the admissions were for kids on Medicaid or SCHIP. But our capacity is very limited. The average time for a new patient appointment is 3 months. It is one of the principal sites in the Commonwealth where Virginia's future child mental health professionals are trained. In view of the recent tragedy at Virginia Tech, this role is of heightened importance. Acknowledging the limited availability of mental health services available in many communities – especially for the uninsured, emergency departments have begun to play a significant role in addressing the issues of patients in need of psychiatric care. The VCU Health System Emergency Department has responded to this need through the creation of programs such as a Crisis Stabilization Unit. This program, which cares for over 450 patients annually, provides an area for patients discharged from the emergency department who still require intervention for up to 23 hours and intensive support for psychiatric issues. With close to 50% of our emergency room volume

represented by Medicaid and indigent patients, there is an ongoing need to make these types of services readily accessible for those in need.

Medicaid Payments for Graduate Medical Education

The teaching hospital mission of training the next generation of physicians has never been more important. According to the U.S. Census Bureau, the number of elderly will double by 2030. With this will come a sizable increase in demand for health care services. According to data from the National Ambulatory Medical Care Survey, patients aged 65 and older typically average six to seven physician visits per year. If the annual number of physician visits continues at this rate, the U.S. population will make 53 percent more trips to the doctor in 2020 than in 2000, which means that we will need to produce many more physicians per year than we are producing now. The Health Resources and Services Administration's (HRSA) Bureau of Health Professions projects that the nation will have a shortage of at least 55,000 physicians by the year 2020. This has enormous implications for health care policy. Indeed, given the amount of time it takes to educate and train a physician—four years of medical school, plus multiple years of residency training—2020 is now, and we must take action immediately. In fact the Federal Council on Graduate Medical Education (COGME) issued a report in 2005, *Physician Workforce Policy Guidelines for the United States, 2000-2020*, that recommended that medical school enrollment be increased and that the cap on resident positions supported by the Medicare program be increased.

Many state Medicaid programs have long recognized the need to make additional payments to teaching hospitals to help offset additional costs these facilities incur as a result of their special missions of educating physicians and caring for patients who require more intense, complex care. Following Medicare's lead, many states have implemented two payments similar to the direct graduate medical education (DGME) payment (for residency education costs) and the indirect medical education (IME) payment (for higher patient care costs) under Medicare's system. According to a study

commissioned by the AAMC, in 2005, 47 states and the District of Columbia provided DGME and/or IME payments under their Medicaid programs. As mentioned earlier, the nation's major teaching hospitals provide a disproportionate amount of health care services for Medicaid beneficiaries and the uninsured, while simultaneously maintaining core missions of medical education, biomedical research, and innovative patient care. Given these vital and unique missions, it is important that the Medicaid program and states be allowed to maintain their financial commitments to teaching hospital missions.

However, CMS's proposed rule would rescind important support for teaching hospitals by seeking to eliminate the payments that support the direct costs associated with residency education. Specifically, the proposed rule would modify 42 C.F.R. §447.201 by adding a new section (c) that states that state Medicaid plans:

> Must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system. . . .

Additionally, the proposed rule would modify the Medicaid upper payment limit (UPL) regulations at 42 C.F.R. §447.272(b) to exclude Medicare direct GME payments from the UPL calculations.

We were surprised and greatly disappointed by CMS' decision to pursue this action given the important role of teaching hospitals in caring for Medicaid patients and training the physicians that serve them. As noted in the attached AAMC comment letter submitted in response to the proposed rule, this rule would undo a history of support that has extended more than twenty years. CMS and its predecessor, the Health Care Financing Administration, have long recognized GME as an authorized Medicaid expenditure and consistently have approved state plans and matched state Medicaid GME payments.

The decision by CMS to propose this action is even more alarming because of the agency's recognition that the "Federal Government has no way to directly determine the number of States making GME payments, amounts States are spending or claiming as GME or the total number of hospitals receiving such payments." Not surprisingly, we believe that the Agency underestimates the impact of eliminating DGME payments partly because of their inability to capture these payments as well as their erroneous assumption that States would use other options to address funding for graduate medical education.[1]

Impact on the Physician Workforce

Because the Medicaid proposed rule on GME would endanger the ability of teaching hospitals to maintain their mission of training physicians, it represents surprising disregard for the future viability of our nation's healthcare system. The timing of this proposal is problematic, as the U.S. faces a looming physician shortage in conjunction with a rise in the healthcare demands of baby boomers. The mission of our teaching hospitals to train the next generation of physicians is more important than ever, yet training programs face severe funding cuts. Eliminating Medicaid GME funding would be dangerously shortsighted.

Medicaid GME payments help teaching hospitals sustain a core responsibility: providing clinical education for future physicians. Within a supervised patient care team of health care professionals, physician residents provide needed care to Medicaid and other patients as part of their training programs. These clinical experiences prepare them for their future independent practice of medicine and help ensure the competencies necessary to care for vulnerable populations. Training future physicians and other health care professionals has never been more important given the numerous studies predicting current and future physician shortages.

[1] Federal Register/ Vol 72, No. 99/ May 23, 2007/ Proposed Rule p. 28935.

Implications for Virginia and VCU

Virginia makes both Direct and Indirect Medical Education payments through Medicaid using methodologies similar to those used to determine Medicare's payments. Payments for to the VCU Health System for Medicaid Direct Medical Education were $6.7M in fiscal year 2007. The federal and state portions of these payments are split approximately 50:50. If these Medicaid GME payments were reduced, or worse – eliminated, our teaching hospital would be faced with a Hobson's choice: reduce costs or curtail efforts to continue to modernize our aging physical plant. I suspect we would most likely choose the former, because, like most teaching hospitals, our physical plant is already disadvantaged compared to other hospitals in the community. And, since our role is to be the place where cutting edge technologies and procedures are first developed, and evaluated, we are in a very capital-intensive environment. For instance, MCV Hospitals was one of 3 teaching hospitals in the U.S. where the techniques for the world's first heart transplant were developed. Thus, most teaching hospitals will be forced to reduce their costs – and reductions in Medicaid GME may lead to reductions in training positions for the physicians who care for Medicaid and other patients. For instance, training slots for pediatricians and obstetricians could be affected, decreasing access for all patients now and in the future. At the VCU Health System, we have 63 pediatric post-graduates and 24 post-graduates in obstetrics and gynecology.

Concern About Other Recent Regulatory Changes to Medicaid

As our fellow panelists have discussed/will discuss in greater detail, CMS has either finalized or proposed several other rules that will further reduce Medicaid payments to hospitals such as mine. My organization is greatly troubled by the impact they will have. Over the past 3 decades there has been a migration of

approximately 750 hospital beds from the city of Richmond to the surrounding suburbs. These beds, which were not replaced, were lost due to the closure of 4 major hospitals in the city, 3 of which subsequently relocated to the suburbs. At the present time, there is only one major hospital in the inner city of Richmond. I am the CEO of the health system that includes that hospital. Thus, the VCU Health System is the last remaining health system in downtown Richmond.

Our nation's teaching hospitals will be the first to celebrate health reform that expands health care coverage to the nation's uninsured and disadvantaged. However, it would be illogical to first reduce Medicaid payments, inter-governmental transfers and upper payment level payments before consensus has been developed on how to expand health care coverage. We know the nation's disadvantaged walk a very thin tightrope – their safety net is threadbare and frayed.

Teaching hospitals are disproportionately represented among the nation's safety net hospitals. Like other teaching hospitals in major metropolitan areas, and those in rural settings, the VCU Health System embraces care of the disadvantaged as one of its core missions – and we do so judiciously, often with innovation. Thus, at VCU, like many teaching hospitals, we have been effective stewards of Medicaid funds. For instance, we established the Virginia Coordinated Care Program (VCC). Through the VCC, we have contracted with under-represented minority primary care physicians in the inner city to see uninsured patients who, otherwise, would crowd our emergency rooms. This program has been funded from our bottom line generated from commercial payors, not from Medicaid, IGT payments or UPL sources.

There have been several moments of moral victory in the fight for health care for the disadvantaged in the nation's history. It began with Title XVIII and Title XIX in 1965, with the enactment of Medicare and Medicaid, respectively. In recent years, there was SCHIP, which added millions of uninsured children to the rolls of those with health care coverage. Now, at the dawn of a Presidential election that promises to include health care as a centerpiece of the debate, why would Congress support a decrease of funding

to the most vulnerable members of our population? At a time when experts are acknowledging significant physician workforce shortages over the next 10 to 15 years, why would Congress adopt a policy that sharply reduces funds for training the current level of graduate physicians?

We are also troubled by the poor policy judgments and unreasonable regulatory process utilized by CMS. In fact, we believe that the language of the proposed rule on Medicaid payments for outpatient services violates the current moratorium by excluding GME costs from the outpatient upper payment limit calculation.

Lastly, there is an additional concern that needs to be acknowledged. Since the middle 1990s, more than two-thirds of state Medicaid programs have moved to develop managed care arrangements for their beneficiaries. Virginia is one of those states, and approximately half of Virginia's Medicaid beneficiaries are enrolled in a managed care plan. And yet, under managed care, Medicaid support for GME is at risk. For instance, while Medicaid managed care rates include historical payments for GME in some states, the managed care organizations are not bound to distribute these dollars to hospitals. Many states make Medicaid GME payments directly to teaching hospitals under capitated managed care, but this policy is inconsistent.

Conclusion

For 40 years, the Medicaid program, major teaching hospitals, and medical schools have collaboratively ensured that all patients, including Medicaid beneficiaries, can access the healthcare services they need. Through graduate medical education training programs and Medicaid GME payments, they have also assured that all patients continue to have a sufficient supply of physicians well into the future.

We believe strongly that if Medicaid's support for teaching hospitals and medical schools deteriorates, then their very missions will be in great jeopardy. If their patient

care, research and educational infrastructure begins to falter, the effects will be extremely difficult to reverse. Most of the uninsured and Medicaid beneficiaries are hard-working Americans who are either self-employed, or are employed in small businesses that cannot afford health care coverage for their employees. Over the past 20 years, despite modest health care reforms, we have made little progress in reducing the total number of our citizens who remain uninsured. For Medicaid, there has been growth in the number of beneficiaries, at least in part because of erosion of employer-based coverage in recent years. In essence, these programs have been necessary for us to stay-in-place. Without the nation's safety net, many of our most vulnerable citizens would have fallen. With 47 million Americans uninsured, and another 40 million on Medicaid, the safety net is stretched tight and teaching hospitals are holding the corners.

I thank you for the opportunity to testify today. I'm sure my fellow teaching hospital and medical school leaders and the AAMC look forward to working closely with you on these issues, which are of such importance to the health and well-being of all Americans.