MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Thursday, April 24, 2003**
**9:40 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM:**

Public comment

MR. HACKBARTH: We'll have a brief public comment period.

MS. FISHER: Brief, but hopefully helpful. thank you, Glenn. Karen Fisher with the Association of American Medical Colleges.

Over the years we've heard concerns sometimes from Commissioners about what medical schools are doing to help respond to future physician workforce needs, et cetera. I'm going to point my comments in two areas. One is to what's going on with geriatric education. And two to the issue of Medicare resident limits, in general.

First, on the geriatric side, the good news is that over the past 20 years, the number of departments and units and specialized areas in schools of medicines that have been devoted to gerontology and geriatrics has increased substantially. The problem is there's still a lag. And as you can see, the problem is the number of physicians who are practicing there is still a problem.

One of the other problems that was pointed out in the presentation that bears repeating is the number of faculty who have geriatrics as their designated specialty. In schools of medicine, faculty play a very important role as role models and in career decisionmaking. And when you don't have faculty who are doing geriatrics, it's hard for them to go and convince people to go into geriatrics training.

On a positive note, in 2000, the AAMC hooked up with the Hartford Foundation and is distributing $4.8 million in grants to 40 medical schools, a not insignificant number of medical schools, to help enhance their gerontology and geriatric curricula. While it's still early in the process, the survey data from graduating seniors indicates that those seniors gradually from what we call those Hartford schools do seem to have a better confidence, a better knowledge about geriatricians and geriatrics, et cetera.

Now whether that will help them make geriatricians as their specialty, we don't know. We hope so. Perhaps as importantly, we hope that as physicians they will pay more attention and have a better understanding in treating older patients. So we think that's some good news that schools of medicines are doing.

I would like to take a moment to talk a little bit about the Medicare resident limits in general. We have a concern about that. As Marian pointed out, they were imposed by the BBA in 1997.

At that time, many people felt that there would be a physician surplus by the year 2000. Most people agree now that 2000 has come and gone that there was not a significant physician surplus. And many people out there now are saying that there may be a shortage, and an impending shortage coming in physicians.

We haven't gone that far, even though our members have

indicated that there are pockets of shortages in certain specialty areas, in certain geographic areas, et cetera, and we believe more research needs to be done in terms of looking at future physician workforce needs.

What we do know is that, we do think the resident limits are having a chilling effect on the ability of programs, the departments and hospitals, to go into new specialties, to expand existing programs, et cetera.

It is a policy that is one of the tightest probably in Medicare. It's very tight with very limited exceptions. The exceptions relate mostly to rural hospitals which, because of their nature, it's not taken advantage of very much. But we think that resident policy is worth looking into.

I'd like to point out, I think we think that the level of the IME adjustment and the resident cap issue is a very distinct issue, particularly as it relates to GME payments in the resident cap issue. I would urge you, in your report, to not entangle the two issues of what the level of the IME amount should be versus whether there should be a resident cap issue in Medicare.

We believe those payments are for two very different purposes, between the direct and the indirect. And you'd have to go into a lot of detail if you wanted to bring up the IME level and relate it to the resident cap issue. We'd be happy to discuss that but we think that entangling those two issues is difficult.

We also are glad to see you not recommending an expansion to the exemption for geriatrics because we think this needs to be addressed at a broader level. There are a number of legislative proposals on the Hill to provide expansions for the cap for various specialties, and we don't believe that's the best way to go, to look at this specialty by specialty. But we think it needs to be looked at in a more global way.

So we would urge MedPAC to look, as you look at your agenda next year, to look at this issue and to think about having a discussion about the Medicare resident limits. This has essentially been a freeze on Medicare resident counts for the past five years. And at least we can't recall when there has been a freeze that has existed with no solution in sight. And by its very nature, freezes tend to be assumed to be temporary in nature. We'd like to have a thoughtful body think about what the next step is and modifications to that.

Now, given our past discussions of the Commission's past discussions on payments to teaching hospitals, I make that recommendation with some hesitancy. But I think the issue is of such import that we're going to go ahead and ask this esteemed body to consider looking at this policy and discuss it at a future meeting.

Thank you.

MS. EMER: I'm Susan Emer with the American Geriatrics Society. I just want to make a couple points.

The first is that when the report was requested back in '99, the fill rate was much higher. It was up at 90 percent. That's something that Marian did mention, but I think it bears repeating. At that point, it was on the increase.

The second point is that. as noted, since then the fill rate has decreased. But I think it bears emphasizing that one of the reasons are the ongoing reimbursement disincentives and then the volatility associated with the update and the fact that geriatricians uniquely have a full Medicare patient base.

And then the other issue, again, is the changes in the CAQ and the fact that this mix affects recruiting patterns, and it's mostly a first year recruitment. And we think that's a short-term transient event, which in future years will change and that the fill rate will then go up.

Basically we feel that the reimbursement issue is something that needs more study, as well, and that that's one of the major reasons for the shortage. I think we do think that the shortage issues could have been discussed more and that's something that future report perhaps can evaluate specifically. What are the reasons for the ongoing shortage and lack of interest in the specialty? And what are some things that perhaps can be recommended to change it?

Finally, I think we'd like to point out that perhaps it's premature to make this kind of recommendation, again based on the shortage issue. And also the fact that we see the certification issues changing after the next year or two.

Thank you.

MR. HACKBARTH: Thank you.