

NATIONAL ASSOCIATION OF URBAN HOSPITALS

Private Safety-Net Hospitals Caring for Needy Communities

July 9, 2004

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue S.W., Room 443-G
Washington, D.C. 20201

**Subject: CMS-1428-P
Graduate Medical Education**

Dear Dr. McClellan:

I am writing on behalf of the National Association of Urban Hospitals (NAUH) to express our opposition to the new regulation proposed by the Center for Medicare & Medicaid Services (CMS) for the reallocation of medical residency slots among the nation's hospitals.

Medical Residency Slots: The Situation Today

As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress directed CMS to develop a new methodology for the reallocation of unused medical residency positions among the nation's teaching hospitals.

Medical Residency Slots: The Proposed Change

In the proposed regulation published in the *Federal Register* on May 18, CMS states that with an overall cap – hospital-specific and nation-wide – on medical residency slots in the U.S. today, hospitals not using all of their slots in a selected year will be required to return those slots *permanently* to the nation-wide pool of available slots. Those newly surrendered slots then would be redistributed by CMS among the nation's teaching hospitals.

Medical Residency Slots: NAUH's Objections to the Proposed Change

NAUH believes that the proposed mechanism for dealing with vacancies in medical residency slots has several serious flaws that need to be addressed.

First, the proposed approach disregards the reasons that any hospital may have vacancies in medical residency slots and assumes instead that any vacancy signifies the lack of a need for the position at the

host institution. This logic is flawed. In recent years, for example, some slots have gone unfilled as certain medical specialties go through a period of unpopularity. For several years, for instance, slots for residents in radiology have gone unfilled as interest in that medical specialty waned. The need for radiologists remained, but for a period of years, medical schools did not produce enough students to meet the demand and positions went unfilled. Likewise, some positions are actually filled and then become vacant during the course of a year: residents become ill and must stop working; some leave for family reasons; some may choose not to pursue medicine further as a career. None of these legitimate, short-term reasons for vacancies suggest the lack of a need for medical residents at the institutions at which the vacancies arise.

Second, NAUH objects to the manner in which residency slots would be reallocated under the proposed regulatory change. Under the proposed change, CMS has established a process for interested hospitals to apply for vacant residency slots. This process would employ newly developed criteria for determining how the slots are to be reallocated. Those criteria, NAUH believes, are extremely unfair: the first five criteria are clearly constructed for the sole purpose of benefiting rural and small hospitals. This whole process, in fact, appears to be designed to use any pretense, no matter how minor, to take residency slots away from urban hospitals and give them instead to rural and small hospitals.

Americans receive the finest health care in the world, and for the most part, American physicians have been trained in urban teaching hospitals. Those teaching hospitals have a track record of excellence, they have demonstrated their ability to train physicians, and they certainly have done nothing to justify lessening their role in this critical process.

Third, NAUH is concerned about the lack of regard this change suggests for the role that medical residents play in the communities in which they work. Often, the teaching hospitals in which medical residents train are located in densely populated, low-income urban areas. Medical residents in these communities play a key role in the provision of health care to the poor, including many Medicaid recipients and many uninsured people. They work in hospitals, staff community clinics, and participate in countless outreach programs. The loss of medical residents, and of Medicare's financial support for these residents, could have a devastating impact on access to health care for low-income residents of urban communities across the country, potentially leaving facilities that have long cared for many low-income patients both understaffed and underfunded. This appears not to have been a consideration in the development of this regulation – but it should be a consideration.

Medical Residency Slots: NAUH's Proposed Solution

NAUH urges CMS to withdraw the portions of the fiscal year 2005 Medicare inpatient PPS regulation that address the reallocation of medical residency slots and to reconsider its position on this issue. While Congress directed the agency to develop a new methodology for redistributing vacant slots, it did not direct CMS to do so in the proposed manner and it certainly did not direct CMS to do so in a manner that could potentially jeopardize access to health care throughout urban America.

Once this proposed change is withdrawn, NAUH urges CMS to work closely with the hospital industry in all parts of the country to develop an approach that more appropriately reflects the needs of the broader American health care system and the communities that medical residents have long served.

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About the National Association of Urban Hospitals

The National Association of Urban Hospitals (NAUH) advocates for adequate recognition and financing of private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These private, urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are much older and poorer; they are far more reliant on Medicare and Medicaid for revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NAUH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for these distinctive private, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

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We appreciate your attention to the concerns we have expressed about the proposed reduction in Medicare IME payments and welcome any questions you have about our organization, this issue, or our rationale for the position we have stated in this letter.

Sincerely,

Ellen J. Kugler, Esq.
Executive Director