

July 10, 2003

Medicare Payment Advisory Commission (MedPAC)  
Attention: Commissioners  
601 New Jersey Avenue, NW  
Suite 9000  
Washington, DC 20001

Dear MedPAC Commissioner:

At the January 2003 meeting, MedPAC voted not to include in the 2003 *March Report* a recommendation to further reduce the Medicare indirect medical education (IME) payment level. We very much appreciate the Commission's decision. We also appreciate the Commissioners' thoughtful discussions about the purpose of IME payments and the relationship between these payments, the roles and responsibilities of teaching hospitals, and the role of the Medicare program.

The 2003 *March Report* indicated your interest in continuing to study and discuss Medicare IME policy. While we recognize that you are aware of the special patient care roles and responsibilities of America's teaching hospitals, we thought you might find it useful to have some of this information available for your discussions. Accordingly, attached is a brief synopsis of some of the service roles, and related activities, that teaching hospitals fulfill and the financial challenges they face.

Given the Commission's focus on Medicare IME payments, this synopsis does not address graduate medical education or the other educational roles that teaching hospitals fulfill. Medicare direct graduate medical education (DGME) payments are intended to cover Medicare's share of the costs associated with physician graduate medical education, including residents' stipends and benefits, faculty supervisory costs, and allocated overhead costs. By contrast, IME payments help offset the higher patient care costs, some of which are attributable to the indirect costs of medical education, and associated services at teaching hospitals. While IME payments are calculated based on a formula that utilizes the number of residents in training, the primary purpose of IME payments is not to fund educational activities.

As you review the appended information, we believe several themes deserve special note:

- The distinctive capabilities and responsibilities of teaching hospitals do not come without costs. Teaching hospitals incur significant unreimbursed costs associated with newly developed devices and technologies; maintaining standby services; treating patients with complex conditions; unfunded and underfunded clinical

research (including health services research); capital requirements; and serving as safety-net providers. These activities impose substantial financial burdens on teaching hospitals as demonstrated by their razor-thin total and operating margins.

- Within broad parameters defined by their overall missions of education, research, advanced clinical care, and community outreach, teaching hospitals are quite heterogeneous, each having their own particular set of activities. This heterogeneity arises from a number of factors, including community and regional needs, research capabilities, and available resources. We believe this variability strengthens the current health care system by reducing redundancy of activities, allowing for economies of scale, and permitting teaching hospitals to adapt rapidly to new challenges and missions.
- While self-evident upon review of the financial data, it is worth emphasizing that IME payments are not used to ensure high margins for teaching hospitals, but rather to support important activities that benefit both Medicare and other patients.
- The array of activities that occurs in teaching hospitals is possible only with a stable source of financial support. Under the current system, Medicare IME payments are critical to maintaining these valuable activities. This dependency is particularly acute, given the current and future financial challenges facing teaching hospitals.

This letter and the attached synopsis do not address the pros or cons of the current methods of financing the special missions of teaching hospitals, or potential alternatives. However, it should be noted that an important strength of the IME methodology is its recognition of the diversity of teaching hospitals. By not binding these payments to specific activities, teaching hospitals can fulfill and tailor specific needs within their overarching responsibilities, based on their own unique capabilities as well as the needs of their local, state and regional populations.

The academic medical community agrees with the sentiment expressed by several Commissioners at recent MedPAC meetings that teaching hospitals and their academic clinical faculties must be leaders in spearheading needed changes to the health care system. Indeed, teaching hospitals and medical schools are actively pursuing new initiatives in each of their missions and are doing so in response to identified needs and in keeping with their leadership roles. The academic medical community understands well that more can and must be done. But to make yet additional changes while simultaneously fulfilling ongoing responsibilities requires a stable and adequate financial base of support.

For nearly 40 years, Medicare has played a critical role in ensuring that the important services provided by teaching hospitals are available to Medicare beneficiaries and other patients. Given the current system, if Medicare's support for teaching hospitals ceases to be adequate, the very infrastructure upon which our nation's health care system rests will begin to falter. And the consequences of that will prove extremely difficult to reverse.

The leaders of America's teaching hospitals and medical schools would welcome the opportunity to discuss with the Commission their ongoing mission-based activities and the importance of Medicare's funding to teaching hospitals.

Thank you for letting me share some of our views with you.

Sincerely yours,

Jordan J. Cohen, M.D.



## **SYNOPSIS**

# **TEACHING HOSPITALS' SPECIAL PATIENT CARE RESPONSIBILITIES AND THE FINANCIAL FOUNDATION SUPPORTING THESE ROLES**

### **Teaching Hospitals Provide Complex Clinical Services**

- Teaching hospitals house 92 percent of all burn care beds in the country, 85 percent of all level-1 trauma centers, 83 percent of all neonatal intensive care unit beds, and 76 percent of all organ transplant centers (2001 American Hospital Association (AHA) Annual Survey data). In a number of states, teaching hospitals are the only source of these services.
- More than 80 percent of major teaching hospitals have cardiac intensive care units, magnetic resonance imaging and cardiac catheterization laboratories (2001 AHA Annual Survey data).
- Teaching hospitals and associated clinical faculty are continuously pioneering and improving on other cutting-edge services such as remote imaging, robotic surgery, and interventional radiology.

### **Teaching Hospitals Treat Very Sick and Complex Patients**

- Teaching hospitals and associated physicians treat three-quarters of the Medicare patients in the 10 highest-weighted diagnosis-related groups (DRGs), and 70 percent of Medicare patients in the 20 highest-weighted DRGs (Analysis of the 2001 MedPAR by the Health Economics and Outcomes Research Institute).
- The nearly 400 teaching hospital members of the AAMC, while comprising only six percent of all hospitals, treated 69 percent of Medicare and non-Medicare patients requiring specialized surgeries and 45 percent of patients with highly specialized diagnoses in 1997 (AAMC Analysis of the Nationwide Inpatient Sample).

### **Teaching Hospitals Foster and Translate Biomedical Research To Benefit Patients**

- Faculty members at medical schools and teaching hospitals received 60 percent of research awards from the National Institutes of Health in 2002.
- By bringing together patients with complex medical problems and research-oriented faculty physicians, teaching hospitals are where basic research is

translated into patient care clinical trials and where future biomedical researchers receive their training.

- The research and training environment of teaching hospitals allows for novel diagnostic and therapeutic treatments for patients for which there is no established cure. Thus, teaching hospitals become the ‘last hope’ not only for the neediest, but for the sickest members of our citizenry.

### **Teaching Hospitals Provide A Range of Patient-Centered Community Outreach Services**

- The typical major teaching hospital is the site of about 51,000 emergency room visits annually, more than four times the volume of its typical non-teaching counterpart (2001 AHA Survey data).
- Over 80 percent of major teaching hospitals provide HIV/AIDS services, nutrition programs, health screening, psychiatric emergency services, and patient representative services, as well as house women’s health centers (2001 AHA Survey data).

### **Teaching Hospitals Have Many New and Expanding Patient Care Responsibilities**

- Teaching hospitals must spend significant resources on new responsibilities relating to homeland security and emergency preparedness, including communication and notification systems; disease surveillance, disease reporting and laboratory identification; personal protective equipment; dedicated decontamination facilities; medical/surgical and pharmaceutical supplies; training and drills; and mental health and community services.
- Teaching hospitals are facing new and expanded research and development responsibilities as a benefit of the recent doubling of the budget of the National Institutes of Health and the sequencing of the human genome. Human genomics and proteomics will transform medical practice and patterns of care delivery, and teaching hospitals will be the launching pads for this veritable revolution.
- Teaching hospitals must prepare and be ready for the emergence and reemergence of new infectious and other diseases, such as SARS, and provide expertise, leadership, and resources when these new threats to public health manifest. Teaching hospitals often partner with state and local public health departments to address these real and potential threats.

## **Major Teaching Hospitals Have Very Low Total and Operating Margins**

- Major teaching hospitals' total and operating margins are consistently and substantially below those of other hospital groups.
- According to MedPAC analyses, the aggregate total margin for major teaching hospitals in 2000 was 1.5 percent, the lowest total margin level in at least the last 10 years (MedPAC 2003 *March Report*, Table D-15).
- According to AAMC analyses, the aggregate total margin for major teaching hospitals in 2001 fell even further, to 1.1 percent. The average major teaching total margin was -0.9 percent, and the median margin was 0.6 percent (AAMC analysis of 2001 Medicare cost report data).
- It is important to remember that total margins generally reflect the best-case scenarios for hospitals because they contain revenues associated with non-patient care activities, most notably investment income.
- The aggregate operating margin in 2001 for major teaching hospitals was -1.7 percent, with average and median operating margins of 0.5 percent and 1.3 percent, respectively (AAMC analysis of 2001 Medicare cost report data).

## **Major Teaching Hospitals' Medicare Margins Require Context**

- The aggregate Medicare inpatient margin for major teaching hospitals in 2001 was 18.2 percent, the lowest level since 1994 and almost one-third less than the MedPAC-calculated 1997 margin of 25.9 percent (AAMC analysis of 2001 Medicare cost report data).
- If Medicare disproportionate share (DSH) payments are removed from the calculation (because their corresponding costs are not reflected in the calculation), the aggregate major teaching hospital Medicare inpatient margin drops to 9.9 percent for 2001 (AAMC analysis of 2001 Medicare cost report data).
- The major teaching hospital aggregate margin under the Medicare outpatient prospective payment system is consistently lower than that of other hospital groups: -17.8 percent compared to -12.0 percent and -13.2 percent for other teaching and nonteaching hospitals, respectively (MedPAC 2003 *March Report*, Table D-6).

## **Teaching Hospitals Face Threats To Their Financial Stability**

- Medicaid payment reductions due to states' financial crises
- Significant upward cost pressures, ranging from workforce shortages to the increasing need for emergency and stand-by preparedness
- Growth in the numbers of underinsured and uninsured persons
- Emergence of specialty, or so-called "carve out," hospitals
- Tiered insurance products that require patients that choose teaching hospitals to pay more in out-of-pocket costs
- Higher than average hospital capital requirements due to the multiple missions and complexity inherent in large organizations
- Rising medical malpractice premiums
- Increased information technology costs.