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December 23, 2008

Medicare Payment Advisory Commission (MedPAC or the Commission)
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Via Electronic Mail

Dear Chairman Hackbarth and MedPAC Commissioners:

On behalf of the Association of American Medical Colleges (AAMC), which represents nearly 300 nonfederal major teaching hospitals and the nation's 130 allopathic medical schools and related clinical physician faculty, I write to urge you to withdraw the draft recommendation to cut Medicare operating indirect medical education (IME) payments to teaching hospitals by 18 percent, totaling more than $1 billion annually, that was presented at MedPAC's December meeting. If the Commission wishes to focus on IME payments, we believe it should adopt the third "option" set forth by Chairman Hackbarth during the Commission discussion "not to reduce [the IME adjustment] at all, at least pending further discussion . . ." (MedPAC December meeting transcript, page 67).

If the draft recommendation is approved and implemented by Congress, the payment cut would directly—and dramatically—affect teaching hospitals' financial status, which could affect their missions of patient care, education and research. These institutions provide an environment where clinical care and scientific discovery flourish in the same settings where the nation's future physicians, nurses, and other health professionals are trained.

Teaching hospitals already are under intense financial pressure. Newspapers are replete with articles about teaching hospitals freezing salaries, cutting staff, or deferring projects because of the ongoing economic downturn. The sagging economy also is resulting in significant increases in charity care costs. On the Medicare front, teaching hospitals are trying to adjust to the elimination of capital IME payments, totaling approximately $385 million annually, as well as absorb the cut in the "large urban" add-on to Medicare capital payments. Moreover, looming on the horizon is the potential elimination of Medicaid graduate medical education (GME) payments when a congressionally-imposed moratorium expires on April 1, 2009. These circumstances are placing intense strain on teaching hospitals as they try to maintain financial stability.

An IME cut of the magnitude being contemplated would be particularly difficult for major teaching hospitals, whose mission-related activities result in overall financial

conditions that often hover near zero and are consistently below those of nonteaching hospitals. In 2006, the most recent year with the most complete Medicare cost report data,[1] an analysis by Vaida Consulting showed an aggregate operating margin for major teaching hospitals of -5.9 percent; the median and average operating margins were -4.4 percent and -7.9 percent, respectively. By contrast, the aggregate operating margin for nonteaching hospitals was 2.0 percent, with median and average operating margins of -0.1 percent and -0.6 percent, respectively. Total margins in 2006 were higher than operating margins, but these margins have fallen considerably this past year because of the significant declines in investment values.

During the December meeting, MedPAC staff noted that the aggregate overall Medicare margin for major teaching hospitals, including capital IME payments, was 1.1 percent, but noted that the margin would essentially be zero after eliminating capital IME payments (0.1 percent). Staff also noted that cutting the IME adjustment would reduce the overall Medicare margin by two percentage points; this would result in a negative 2 percent margin. We do not believe that the Commission should endorse a recommendation that would create a negative Medicare margin for a group of hospitals that disproportionately treats Medicare patients.[2] In addition, although reducing the overall Medicare margin for major teaching hospitals would narrow the gap in these margins between major teaching and nonteaching hospitals (as suggested at the December meeting) such an action would exacerbate the gap in operating and total margins between these groups because it would reduce the operating and total margins for major teaching hospitals whose margins already are lower than the other groups. Because operating margins reflect the real life financial capabilities of hospitals to provide care, such a result is inequitable and inappropriate.

As the Commission contemplates the prudence of an IME recommendation, we urge you to also consider that, because of physician workforce needs and their commitment to their educational missions, many teaching hospitals have increased their number of residents beyond the 1996 caps. Consequently, as of 2006, more than one-half of all teaching hospitals had IME resident counts exceeding their caps by an aggregate of approximately 7,600, and DGME counts that exceeded their caps by an aggregate of approximately 6,800.[3] These hospitals receive no DGME payments associated with these additional residents and no additional IME payments associated with the patient care costs that result from the increased teaching intensity.

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[1] FY2006 corresponds to fiscal periods beginning between 10/1/2005 and 9/30/2006.
[2] Major teaching hospitals (those with an intern/resident-to-bed (IRB) ratio of 0.25 or higher) represent six percent of all hospitals but are the sites for 16 percent of Medicare discharges.
[3] AAMC Analysis of Medicare cost reports, October 9, 2008 release. The numbers differ for DGME and IME because the rules for counting residents differ somewhat for DGME versus IME payments. The data reflect short-term general, non-federal acute care teaching hospitals (excluding hospitals in Maryland and Puerto Rico).

In addition, we point out that the Medicare outpatient PPS system does not include any type of IME adjustment, despite the negative Medicare outpatient margins of major teaching hospitals. Major teaching hospitals' outpatient margins are significantly lower than those of other hospital groups,[6] indicating that the outpatient PPS may not appropriately reflect services provided, and number of patients treated, in teaching hospitals' emergency rooms and outpatient clinics

Recent regulatory interpretations of the Medicare IME and DGME statutes already are eroding Medicare support for the special missions of teaching hospitals by limiting hospitals' resident FTE counts that are included in the calculations of IME and DGME funding. For example, under the FY 2007 Medicare inpatient PPS final rule, CMS stated that teaching hospitals may not include in their IME resident count any time that a resident spends in grand rounds, conferences, or other "didactic" activities, regardless of whether these activities occur in the hospital or in a nonhospital setting.[4]

The financial impact of such a position is a *de facto* cut in IME payments because <u>no</u> resident can be counted as a full FTE for IME payment purposes since all residents must spend at least part of their training time in didactic activities. Equally disturbing is that from an educational perspective, CMS's policy sends a message to the academic medical community that the Medicare program does not value the full range of education activities necessary to train a physician.[5]

At the December meeting, a number of Commissioners commented on the need for further discussions of teaching hospitals' "accountability" for the IME payments they receive beyond the empirically-derived amount. We support such discussions. At the outset, however, it is worth emphasizing that IME payments are not used to produce high margins for teaching hospitals. Rather, they support important activities that benefit both Medicare and other patients. Academic medicine leaders would welcome the opportunity to discuss with the Commission the many ways their institutions are contributing to society and their communities through various mission activities.

Within broad parameters defined by their overall missions of education, research, advanced clinical care, and community outreach, teaching hospitals are quite heterogeneous, each having its own particular set of activities. This heterogeneity arises from numerous 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.

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[6] In 2006, major teaching hospitals had a -22.8 percent aggregate Medicare outpatient margin, compared to -9.8 percent for other teaching hospitals, and -10.0 percent for non-teaching hospitals.
[4] For DGME payments, only didactic activity that occurs within the hospital complex is countable.
[5] To learn more about this policy and our position, you may access our inpatient comment letter at http://www.aamc.org/advocacy/library/teachhosp/corres/2006/061206c.pdf

While many mission-related activities currently are in place for teaching hospitals and their clinical faculty, the academic medical community understands well that more can and must be done. It is with this understanding that many of our members are taking a leadership role and investing heavily in health information technology, implementing some form of a "medical home," and examining their hospital-physician alignments to seek efficiencies and improve the care process.

The current health care system is on an unsustainable course. Our membership is committed to addressing issues of access, cost and quality and to ensuring that Medicare's investment in teaching hospitals continues to benefit the health of the nation and its communities. As the country moves towards a better health care system, however, it is important that the financial condition of teaching hospitals not be destabilized by a $1 billion cut, threatening their capabilities to make desired improvements. We urge the Commission to rescind the draft IME recommendation.

In addition, we ask MedPAC to recommend a full market basket update for the Medicare inpatient and outpatient payment systems. We also urge the Commission to recommend a physician payment update that reflects the increase in physician input prices without any downward adjustments.

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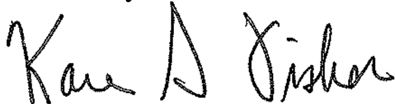
On behalf of the AAMC, thank you for this opportunity to share some of our views with you. We very much would welcome the opportunity to work with the Commission on issues to improve the health of Medicare beneficiaries and the nation as a whole. If you have any questions, please feel free to contact me at 202-862-6140 or kfisher@aamc.org.

Sincerely Yours,



Karen S. Fisher, J.D.
Senior Director
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cc: Mark Miller, Ph.D., Executive Director, MedPAC