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January 4, 2007

Glenn M. Hackbarth, J.D.  
Chair, Medicare Payment Advisory Commission  
64275 Hunnell Road  
Bend, OR 97701

Dear Mr. Hackbarth:

Throughout the fall, the Commission has spent considerable time discussing Medicare indirect medical education (IME) payments. On behalf of the Association of American Medical Colleges (AAMC), which represents nearly 300 nonfederal major teaching hospitals and the nation's 125 allopathic medical schools, I write to briefly summarize our perspective on the fall discussions and the importance of IME payments to major teaching hospitals.

At the outset, I would like to express our appreciation for the Commission's thoughtful discussions about the purpose of IME payments and the relationship among these payments, the roles and responsibilities of teaching hospitals, and the role of the Medicare program. We also appreciate the opportunities afforded AAMC staff to meet with MedPAC staff.

### **The Financial Picture for Major Teaching Hospitals**

The Medicare program and teaching hospitals share a long and mutually beneficial history. Since 1965, Medicare has recognized and provided financial support to teaching hospitals for their unique roles extending beyond the normative patient care services. These include being sites for the clinical education of all types of health professional trainees; providing environments in which clinical research can flourish; being sources of specialized, unique, and referral/standby services; and serving as safety net providers for the poor and uninsured. Because of their education and research missions, teaching hospitals typically offer the newest and most advanced services and equipment, and often care for the nation's sickest and most complex patients. Most recently, major teaching hospitals are looked to as front-line responders in the event of a biological, chemical or nuclear attack and are implementing plans to fulfill that role.

Undertaking these missions has important financial consequences. Thus, it is not surprising that the aggregate total margin for the nation's major teaching hospitals is consistently and significantly below that of other hospital groups. In some years, the margins have hovered near zero. In 2004, the most recent, most complete data available, the aggregate total margin for major teaching hospitals (those with an intern/resident-to-

bed (IRB) ratio of 0.25 or more) was only 3.4 percent; half of teaching hospitals had total margins less than 2.4 percent. By contrast, the aggregate total margin for other teaching hospitals was 5.0 percent, and 4.7 percent for nonteaching hospitals.<sup>1</sup>

Total margins often reflect the “best-case” scenario for hospitals because they reflect revenues associated with non-patient care activities. Operating margins reflect a much bleaker picture for major teaching hospitals. The 2004 aggregate operating margin was -8.3 percent, with the typical major teaching hospital having a -5.0 percent operating margin (the average was -10.5 percent). By contrast, other teaching and nonteaching hospitals had aggregate operating margins of 0.6 percent and 1.5 percent respectively.

### Hospital Total and Operating Margins, by Teaching Status, 2004

Hospital Type	Total Margin			Operating Margin		
	Aggregate	Average	Median	Aggregate	Average	Median
Major Teaching	3.4%	1.5%	2.4%	-8.3%	-10.5%	-5.0%
Other Teaching	5.0	2.9	3.6	0.6	-1.5	-0.6
Non-Teaching	4.7	2.5	3.3	1.5	-2.0	-0.5

*Source:* Vaida Health Data Consultants, Analysis of Medicare HCRIS Database, June 30, 2006 Update

The special payments made by Medicare to teaching hospitals help ensure the financial viability of major teaching hospitals. Thus, it is not surprising, and is quite consistent with the missions of these payments, that Medicare margins for major teaching hospitals are higher than for other groups. In addition, because the primary purpose of Medicare disproportionate share (DSH) payments is to help offset the costs associated with uninsured patients rather than Medicare patients, we agree with comments made by several Commissioners that these payments should be excluded when calculating Medicare inpatient and Medicare overall margins. When these payments are removed, both aggregate Medicare inpatient and overall margins for major teaching hospitals are negative, -1.0 percent and -5.5 percent respectively.

Hospital costs and cost growth are a key component when assessing hospitals’ financial conditions. Because of their fragile overall financial conditions, major teaching hospitals must be diligent about resource spending. Despite unprecedented cost pressures, major teaching hospitals have been able to constrain their cost growth below that of other hospital groups. Between 2000 and 2004, Medicare operating costs per case (adjusted for case mix) grew an average of 5.5 percent for major teaching hospitals, compared to a growth of 6.4 percent for other teaching hospitals, and 6.6 percent for nonteaching hospitals.<sup>2</sup>

<sup>1</sup> 2004 Margin Analysis conducted by Vaida Health Data Consultants (using the June 30, 2006 HCRIS Update). Unless otherwise indicated, all margin figures were obtained from this analysis.

<sup>2</sup> AHA analysis of Medicare operating cost per case growth, using the March 31, 2006 HCRIS Update.

### **Recent Medicare Policies Affecting IME Payments**

The Balanced Budget Act of 1997 (BBA) initiated the start of a multi-year 30 percent across-the-board reduction in the IME adjustment, from 7.7 percent to 5.5 percent, although the current IME adjustment is only 5.35 percent.<sup>3</sup> At the same time, the BBA also implemented a hospital-specific resident “cap” that eliminates Medicare IME and DGME payments associated with residents above each hospital’s 1996 count of resident full time equivalents (FTEs).

Because of physician workforce needs and the commitment to their educational missions, a number of teaching hospitals have increased the number of residents they train beyond their 1996 caps. Consequently, as of 2004, almost half of all teaching hospitals had IME resident counts exceeding their caps by an aggregate estimate of 4,884.<sup>4</sup> These hospitals receive no Medicare IME support associated with the additional residents.

Recent regulatory interpretations of the Medicare IME and direct graduate medical education (DGME) statutes have further eroded Medicare support for the special missions of teaching hospitals and, we believe, are having a detrimental impact on the educational missions of teaching hospitals. Questionable and narrow interpretations of DGME and IME policies have resulted in teaching hospitals and their academic leaders often being forced to choose between retaining critical DGME and IME support dollars or ensuring that residents spend time in ambulatory training sites, are exposed to clinical research activities, and keep up with the latest developments in scientific and quality initiatives.

One recent example is in the FY 2007 Medicare inpatient PPS final rule in which CMS finalized a so-called “clarification” which prohibits teaching hospitals from including in their IME resident count any time that a resident spends in grand rounds, conferences and other “didactic” activities, regardless of whether it occurs in the hospital or in a nonhospital setting.<sup>5</sup>

We strenuously disagree with the CMS position. However, until the policy is changed, the financial impact is a de facto cut in IME payments because no resident can be counted

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<sup>3</sup> Under current law, the adjustment will be 5.5 percent as of October 1, 2007.

<sup>4</sup> AAMC Analysis of the August, 2006 HCRIS Update. The analysis reflects data from the 950 IPSS teaching hospitals listed on the inpatient final rule impact file that had both IME cap and count data on the cost reports available from HCRIS. These data were modified to reflect cap increases and decreases resulting from the resident limit redistribution program that went into effect on July 1, 2005. Note that almost half of all teaching hospitals (438) had resident counts in 2004 that were, in aggregate, 2,974 below their associated resident caps. The result is that in 2004, resident counts exceeded the resident caps by 1,910 for IME payment purposes. The numbers are different for DGME payments because the rules for counting residents differ somewhat for DGME versus IME payments. For DGME payment purposes, hospitals with resident counts above their caps had an aggregate 4,239 difference but the net was only 1,081.

<sup>5</sup> For DGME payments, only didactic activity that occurs within the hospital complex is countable.

as a full FTE for IME payment purposes since all residents spent some time in didactic activities. From an educational perspective, CMS' policy sends a message to the academic medical community that the Medicare program does not value essential and integral educational activities that do not involve direct "hands on" patient care.<sup>6</sup>

### **MedPAC's Draft IME Recommendation**

At the December meeting, the Commission discussed a draft recommendation that would reduce the IME adjustment by one percentage point if and when a severity adjustment to the inpatient diagnosis-related group (DRG) system is implemented. While the draft recommendation stated that the funds resulting from the reduction should be used to increase base DRG payments, subsequent Commission discussion contemplated including the funds in an all hospital pay-for-performance pool, or a fund to encourage residency training innovations at teaching hospitals. In addition, we believe, but it was unclear from the discussion, that the one percent reduction was meant to be illustrative-reflecting MedPAC staff estimates of the increase in DRG payments that teaching hospitals would receive if a severity adjustment were implemented.

We appreciate and share the Commission's desire that the DRG system be modified to better reflect patient severity. Major teaching hospitals tend to treat the sickest and most complex patients. Providing Medicare payments that more closely align with the higher costs of treating these patients makes sense from both policy and practical perspectives.

However, we are concerned about linking an IME payment reduction with this change. First and foremost, the overall financial condition of major teaching hospitals does not support any reduction in IME payments. Second, while MedPAC's recommendation to reduce IME payments is premised on implementation of a severity adjustment, CMS has yet to propose a severity adjustment system and it is not known to what extent such a system will fully address patient severity cost differentials. Moreover, CMS has recently implemented, or is considering implementing, a number of other changes to the DRG system that will, or could have, a significant impact on teaching hospitals. These include adding an occupational mix adjustment to the hospital wage index, other changes to wage index policies, and altering the standardization process when setting DRG weights.

We believe that, at a minimum, the FY 2008 IME adjustment level of 5.5 percent is necessary to help support the missions of teaching hospitals. We also believe that the current draft recommendation to reduce the IME adjustment is at best premature. We urge MedPAC to rescind the draft recommendation. If there is strong Commission desire to address this issue, we suggest that a discussion be included in the chapter text.

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<sup>6</sup> 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>. The issue also is addressed in the inpatient final rule (see August 18 Federal Register at pages 48080-094).

In addition to the discussion on the inpatient IME adjustment in the forthcoming March Report, we urge MedPAC to include in the chapter a recommendation that CMS conduct an analysis to determine whether there should be an IME-type adjustment in the outpatient PPS. Major teaching hospitals have negative Medicare outpatient margins that are significantly lower than those of other hospital groups,<sup>7</sup> indicating that the outpatient PPS may not appropriately reflect services provided and patients treated in teaching hospitals' emergency rooms and outpatient clinics. The outpatient PPS statute provides CMS with the authority to include an IME adjustment and the recently implemented prospective payment systems for both psychiatric and rehabilitation facilities contain IME adjustments.

### **Conclusion**

It is beyond the scope of this letter to address the pros and 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 the overarching responsibilities associated with teaching hospitals based on their own unique capabilities and the needs of their local, state and regional populations.

The academic medical community agrees with the sentiment expressed by some Commissioners that teaching hospitals and their academic clinical faculties must be leaders in spearheading needed changes to the health care system. Teaching hospitals and medical schools are pursuing initiatives related to all aspects of their missions that are intended to respond to identified needs and to provide necessary leadership. While much activity has been undertaken, the academic medical community believes that more can and must be done. However, making these important changes while simultaneously fulfilling ongoing responsibilities requires a stable and adequate financial base of support.

For 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.

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<sup>7</sup> In 2004, major teaching hospitals had a -17.5 percent aggregate Medicare outpatient margin, compared to -7.3 percent for other teaching hospitals, and -8.0 percent for nonteaching hospitals.

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We believe strongly that, under the current system, if Medicare's support for teaching hospitals waivers, and the infrastructure that has been the bedrock of our nation's health care system begins to falter, the effects will be extremely difficult to reverse.

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

Sincerely Yours,



Robert M. Dickler  
Senior Vice President  
Division of Health Care Affairs

cc: Mark Miller, Ph.D, MedPAC Executive Director  
Karen Fisher, AAMC