

## ISSUE SUMMARY

Fifty years ago, Medicare made a commitment not only to provide health care for the elderly but also to help train a sufficient number of physicians to meet the needs of the country. Medicare must continue to provide sufficient and stable funding for direct graduate medical education (DGME) and the indirect medical education (IME) adjustment. This funding supports teaching hospitals as they train new physicians to meet the increasing requirements of an aging population and helps pay for the additional patient care costs incurred by teaching hospitals for the services they provide and the patient populations they treat. In addition, although the Affordable Care Act (ACA) reduced the number of uninsured in this country, safety net hospitals continue to need Medicare Disproportionate Share Hospital (DSH) funding to provide uncompensated care for the large numbers of patients who are still uninsured and underinsured. Finally, teaching hospital outpatient departments (HOPDs) are critical access points for many Medicare patients. These sites cannot sustain further payment cuts.

### Issue

Major teaching hospitals and physician faculty practices serve a disproportionately large volume of Medicare beneficiaries. Teaching hospitals, many of which are safety net providers, care for vulnerable populations who often cannot seek treatment elsewhere. Simultaneously, teaching hospitals are tasked with training future physicians, as well as other health care providers, to meet the nation's health care needs. Projections show the country will need between 61,700 to 94,700 new physicians in the next 10 years. In 1997, as part of the Balanced Budget Act, a hospital-specific limit ("cap") was placed on the number of residents that a teaching hospital can count for purposes of receiving DGME and IME payments. However, because of their educational mission and the looming physician shortage, about half of the teaching hospitals are training residents in excess of their caps, with no additional IME or DGME payments. With shrinking clinical margins, if these payments are not maintained it will be a challenge for teaching hospitals to continue to support their teaching and clinical care missions.

It is imperative that Congress continue to ensure that Medicare supports teaching hospitals through the DGME payment, the IME payment adjustment, and Medicare DSH payments. Cuts to funding would directly threaten teaching hospitals' ability to provide quality care to Medicare beneficiaries and other patients. Spending must be stable and predictable to allow teaching hospitals to continue to train the nation's future physicians and carry out core missions to provide quality patient care, conduct research, and teach the next generation of this nation's physicians.

While representing just 5 percent of the nation's hospitals, AAMC-member teaching hospitals provide 35 percent of total hospital charity care in this country. Congress recognized the importance of teaching hospitals in providing access to low-income patients and established the Medicare DSH payment to help alleviate operating costs associated with treating these patients who often are sicker or have more complex conditions than other patients. Medicare DSH payments have decreased under provisions of the ACA based on the expectation that the percentage of uninsured individuals would decline. Yet, Medicare DSH payments remain a critical resource for major teaching hospitals that continue to provide a disproportionate amount of uncompensated care to low-income patients.

To care for these challenging and underserved patient populations, teaching hospitals often place remote HOPDs in the community. Medicare historically has recognized that HOPDs are essential care settings in the health care landscape and that they differ from physician offices and ambulatory surgical centers in key ways that warrant different payment methods and rates. This payment differential appropriately accounts for the differences in the patients treated, services provided, and regulatory burden at HOPDs. For example:

- HOPDs are frequently the sole sources of care for low-income and otherwise underserved populations of Medicare beneficiaries, accepting those who otherwise face difficulty being seen in physician offices.
- HOPDs need to meet the myriad regulatory requirements of their association with a hospital, including compliance with hospital conditions of participation and providing standby care not provided in a physician's office.

- HOPDs are settings for comprehensive and coordinated care for patients with chronic or complex conditions. Many centers of excellence are based in hospital settings and provide outstanding team-based, patient-centered care.
- HOPDs provide wraparound services, such as translators and other social services.

## Background

Today, there are more than 55 million Medicare beneficiaries, more than three-quarters of whom are over the age of 65. Close to half of all beneficiaries live with four or more chronic conditions, and one-third may not be able to function independently because of one or more limitations in activities of daily living, such as eating or bathing. In the coming years, the ranks of the Medicare population will swell as increasing numbers of the “baby boom” generation reach age 65. At the same time, however, the United States is facing a looming physician shortage. Teaching hospitals account for 20 percent of all Medicare inpatient days and provide clinical training for nearly three-quarters of all medical residents.

The distinctive capabilities and responsibilities of teaching hospitals do not come without a price. Teaching hospitals incur significant costs associated with training new physicians and other health care professionals. They also have costs associated with using newly developed devices and technologies, maintaining standby services, treating patients with complex conditions, providing unfunded and underfunded health services, being sites for clinical research, and serving as safety net providers. These activities impose substantial financial burdens on teaching hospitals. Congress established several payment adjustments to help teaching hospitals with their operating costs. Teaching hospitals continue to rely on these payments to train new physicians and provide high-quality care to low-income patients. These unique services benefit not only Medicare beneficiaries but all patients in the community.

Medicare also provides two additional distinct payments to teaching hospitals. The Medicare DGME payment is a vital source of funding for teaching hospitals that educate the physician workforce of the future. However, Medicare only pays its “share” of these costs, based on a teaching hospital’s ratio of Medicare inpatient days to total inpatient days.

Despite its label, the IME adjustment is a patient care add-on payment intended to help pay for the higher costs incurred by teaching hospitals due to a number of factors, such as treating a more complex patient population, having full service facilities for care, supporting the educational mission, and providing services that benefit the community, such as burn units, that often are unavailable elsewhere. Like DGME payments, because IME payments are an add-on to each Medicare discharge, Medicare is only paying its share of these higher costs.

The Bipartisan Budget Act of 2015 included a new hospital payment policy (Sec. 603) that reduced payment rates at newly established off-campus HOPDs to equal those of physician offices or ambulatory surgical centers (ASC). As of November 2, 2015, any site that enters into a Medicare provider agreement but is not located on the hospital main campus and is located more than 250 yards away from the main campus must be paid according to the ASC prospective payment system or the Medicare Physician Fee Schedule (PFS). This so-called “site neutral” policy disregards the critical and real differences between HOPDs and physician offices, including the increased costs of providing care in an outpatient setting, the complex case mix of patients seen there, and their essential role in medical education. While existing HOPDs were grandfathered and not subject to the new payment policy, sites that were under development or “mid-build” were not addressed. The AAMC strongly supports policies that would exempt “under development” off-campus HOPDs, as well as grandfathered HOPDs that relocate, renovate, or add services.

## AAMC Policy Recommendations

To sustain our nation's teaching hospitals and the irreplaceable services they provide, the AAMC urges the following steps be taken:

- Lift the Medicare resident caps.
- Maintain the DGME payment and IME adjustment at their current levels.
- Adequately increase Medicare DSH payments to ensure appropriate reimbursement for teaching hospitals as they continue to see an increase in the disproportionate number of uninsured and underinsured patients they care for.
- Refrain from additional reimbursement reductions in Medicare HOPD payment policy.
- Implement policies that provide flexibility for existing HOPDs and relief for hospitals with HOPDs that were mid-build when the Bipartisan Budget Act of 2015 was passed.

## Related Issues

- Medicare Physician Payment and Quality
- Medicaid
- Physician Workforce Issues

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## Web Resource

### AAMC Information on Teaching Hospitals

[www.aamc.org/newsroom/keyissues/teaching\\_hospitals](http://www.aamc.org/newsroom/keyissues/teaching_hospitals)