



**Association of
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October 14, 2019

Francis J. Crosson, MD
Chairman, Medicare Payment Advisory
Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Dear Dr. Crosson:

I am writing to you on behalf of the Association of American Medical Colleges (AAMC) to follow-up on the September 6 MedPAC discussion about the Indirect Medical Education (IME) adjustment with some thoughts and information that I hope will be useful. The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The AAMC strongly supports the addition of an outpatient IME adjustment, but it should be **in addition to** the inpatient IME adjustment which remains essential to the financial health of teaching hospitals. The IME adjustment allows teaching institutions to treat the most vulnerable and complex patients and make critical stand-by and other services available all patients and their communities. I appreciate that the staff presentation did not suggest cutting the total amount of money for the IME adjustment, but the redistributive effects would likely be significant and would harm the very hospitals that Congress recognized merit this payment. We would be very pleased to meet with you and your staff to discuss options for the development of an outpatient IME.

IME is about patient care

Over the decades, we often are reminded that describing the role and critical purpose of the IME adjustment is a challenge. Although two Medicare payments — direct graduate medical education (DGME) and IME — share an “education” label, each serves a distinct purpose: DGME is about the costs of training the future physician workforce and IME relates to costs that are incurred for patient care. Although at times the September 6 discussion veered into issues that should be part of a DGME discussion, it was promising to see that several Commissioners as well as staff noted that workforce issues, including specialty mix and pipeline issues, are in the province of DGME discussions while the

IME adjustment is about patient care, including the types of patients treated and the services that are maintained by teaching hospitals.

However, even during the staff presentation, we witnessed conflation of the DGME and IME payments. Specifically, staff suggested that “[t]his new program could support workforce skills needed in a delivery system that reduces cost growth while maintaining or improving quality” (slide 14). We believe that workforce skills are in the domain of DGME, not IME. The Accreditation Council for Graduate Medical Education (ACGME), which is the accrediting organization for all residency programs, has already established standards that have been developed and refined by experts in each specialty to ensure that residents are trained to practice in the twenty-first century health care system. This includes competencies and a new program on milestones that each resident must meet and details about the skills that are needed to move to the next training level. I would be pleased to discuss with you and arrange a meeting with ACGME staff so that you can understand the ways in which that organization ensures that resident training meets the needs of the nation.

Medicare does not overpay teaching hospitals

Both inpatient and outpatient Medicare margins for teaching hospitals are negative, and for many of these hospitals, overall margins are also negative. Before MedPAC begins developing a recommendation regarding IME, a much more granular analysis is needed. For example, while staff estimated the impact of the change on “overall Medicare payments across all lines of business” to be 2 percent, the impact on individual teaching hospitals’ Medicare margins and overall margins was not shown. According to MedPAC staff, “about a fifth of teaching hospitals would have more than a 25 percent decrease, and a sixth would have more than a 25 percent increase in IME payments.” In essence, the proposed change in IME would cut payment to many teaching hospitals and further jeopardize their ability to continue to care for Medicare and all patients and provide the variety of services that are not available elsewhere.

Teaching hospitals are where Medicare beneficiaries can find inpatient care that is not available elsewhere

The IME adjustment supports the ability of teaching hospitals to be key components of the health care system, a significant benefit to Medicare patients. Teaching hospitals are different from other hospitals. They provide specialized care to patients — Medicare beneficiaries and others — who are sicker than patients at nonteaching hospitals. As the table below shows, patients at teaching hospitals have a longer length of stay and a higher aggregate case mix, and teaching hospitals have higher occupancy rates. This is evidence that teaching hospitals are treating the patients who cannot get the care they need at other hospitals.

	Median Length of Stay (days)*	Aggregate Case Mix**	Median Occupancy Rate
AAMC-Member Teaching Hospitals	5.7	2.05	76%
Other Teaching Hospitals	4.7	1.75	64%
Nonteaching Hospitals	4.4	1.63	46%

*Not adjusted to reflect case mix.

**Based on 2016 Medicare claims data

Data reflect short-term, general, nonfederal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members

Source of LOS and median occupancy is the FY2017 American Hospital Association Annual Survey Database

Further, research conducted by the AAMC using 2016 Medicare claims data found that Medicare transfer patients represent nearly 11 percent of teaching hospitals' inpatient cases compared with 3 percent at nonteaching hospitals.¹ Relatedly, a recent AAMC-Healthcare Financial Management Association study published in *Academic Medicine*² found that teaching hospitals treat a disproportionate number of transfer cases. While teaching hospitals represent less than a third of inpatient PPS hospitals, they treat roughly 80% of all Medicare transfer patients. These patients are sicker than non-transfer patients, with their treatment costs being 51 percent more, in part because they need to spend more days in the hospitals and have higher average daily costs. Additionally, a recent study in the *Journal of the American Medical Association (JAMA)*³ found that mortality rates at teaching hospitals are significantly lower than at nonteaching hospitals. These crucial benefits to the Medicare population provide compelling evidence that Medicare's support of our teaching hospitals is working.

An outpatient IME is needed, but not at the expense of inpatient IME

To create an outpatient IME, MedPAC staff suggested a reduction in the inpatient IME, the creation of a consistent methodology for fee-for-service and Medicare Advantage (MA) inpatients based on average daily census, elimination of capital IME, and establishment of a performance-based component for a significant portion of IME payments. These changes would be budget neutral so that, in aggregate, the amount of IME would remain the same. Staff noted that "many teaching hospitals would have material changes in their IME payments," and suggested that a transition policy would mitigate the impact. As discussed previously in this letter, only aggregate data was presented, meaning the impact on individual teaching hospitals is unknown, and the broader impact of the changes on the health care system also was not discussed.

¹ Kelly B, Iyer P, Xu S. Teaching hospitals are critical providers of care for Medicare hospital transfer patients. AAMC Analysis in Brief. 2019;19(2).

² Baker, MC, Koopman, CJ, Landman, JH, et al. Financial and clinical impact of transfer patients at major teaching hospitals, *Academic Medicine*, June 25, 2019. Retrieved at: https://journals.lww.com/academicmedicine/Abstract/publishahead/Financial_and_Clinical_Impact_of_Transfer_Patients.97548.aspx.

³ Burke LG, Frakt AB, Khullar D, Orav EJ, Jha AK, Association between teaching status and mortality in US hospitals. *JAMA*, 2017;317(2):2105-2113.doi:10.1001/jama.2017.5702

The AAMC agrees that payments for outpatient department services should include an IME adjustment. Teaching hospitals treat sicker patients in their outpatient clinics, provide coordinated care, and have available services, such as behavioral health, that are rarely available elsewhere. The latest data⁴ show that for all members of the AAMC's Council of Teaching Hospitals and Health Systems, the baseline Medicare outpatient margin for FY2016 was -22.74%. However, the outpatient IME should not come at the expense of the inpatient IME, which is critical to the financial health of teaching hospitals, their communities, and the nation. Although overall the amount of IME would remain the same— taking into account combined inpatient IME, outpatient IME, and a performance bonus — it is unclear how the system could be implemented.

More work needs to be done

According to MedPAC staff, “about a fifth of teaching hospitals would have more than a 25 percent decrease, and a sixth would have more than a 25 percent increase in IME payments.” If a performance-based component were added, the shifts could be even larger for certain hospitals. Before further development of this concept, a threshold analysis should be done to show the precise nature of the impact on individual teaching hospitals. Other issues that need further elucidation include:

- **The most appropriate way to measure teaching intensity.** Staff proposed using average daily census across all payers to account for both inpatient and outpatient use, scaled up by the hospital's inpatient and outpatient revenue relative to its inpatient revenue. Teaching intensity is a proxy for the additional patient cost burden of teaching hospitals. Many studies have confirmed that the IRB ratio remains the best proxy for teaching intensity, even on the outpatient side. I would be happy to study and explore alternatives for measuring teaching intensity with your staff.
- **The impact of the elimination of Capital IME.** Due to the small amount of inpatient capital IME, staff assumed that the elimination of this payment would not be significant. More work needs to be done to determine the full effect. For instance, staff said that “residents do not systematically affect hospitals' capital costs.” This fails to account for the fact that the presence of residents means that patient rooms need to be larger to account for more providers and learners being in patient rooms, that services requiring capital expenditures are available in teaching hospitals because residents are being trained, and that hospitals are committed to having cutting edge technologies available as a benefit of training and patient care.

It is premature to include a performance-based component

In 2010 when MedPAC recommended a performance-based component for teaching hospitals, the recommendation involved taking money from the inpatient IME and using it to fund a performance-based GME program. The recent September discussion seems to be about the creation of a performance-based component that would comprise a significant portion of the IME adjustment. As one commissioner pointed out, the \$1.1 billion performance-based component essentially is a withholding of

⁴CMS, HCRIS Database, September 30, 2018 update; critical access hospitals in Maryland and Puerto Rico not included in the calculations; cost report with ratios of revenue to cost outside the interval of +/- three standard deviation from the geometric mean were not included in the calculation of aggregate statistics.

about 11 or 12 percent. The impact on teaching hospitals would come at a time when margins already are negative and the Medicare population continues to rapidly expand. Another Commissioner put it more bluntly when she said of the performance-based component, “I think we should dump it.” It is unclear what type of metrics would be appropriate for an IME adjustment.

We and our members believe that providing high quality care to all patients is part of our missions. Our members consistently strive to give that level of care to all patients in all care settings. As is true for all hospitals, teaching hospitals already are subject to numerous quality programs — none of which are appropriately risk-adjusted for the social determinants of health — so it is unclear what types of additional metrics MedPAC staff and Commissioners may be contemplating. As we discussed earlier, ACGME establishes and refines standards for residency training to ensure that our physicians remain the best-trained in the world. We do not think another performance-based system is appropriate, but we would be happy to begin exploring whether there are any reasonable options that might be considered in the future.

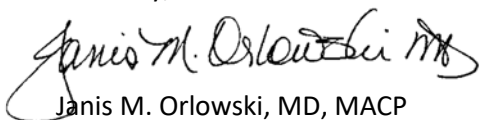
The concentration of teaching hospitals and resident training is a plus

MedPAC staff cite the fact that the 100 teaching hospitals with the highest IME payments account for 47% of all residents and 51% of IME payments (see slide 9 of MedPAC Presentation September 6, 2019). However, it is not clear how this data relates to the implementation of a new IME payment methodology. It is reasonable to assume that the most IME dollars will be found where the most residents are trained. A strong system of teaching hospitals is essential to our health care system.

Summary

Teaching hospitals are a vital force in the health care system but are facing negative Medicare margins and some are facing negative overall margins. While the AAMC fully supports the creation of an outpatient IME, this should not be done at the expense of the inpatient IME. I will be contacting you shortly to find a time when we can meet to discuss this further.

Sincerely,



Janis M. Orlowski, MD, MACP
Chief Health Care Officer

Cc: James E. Mathews, Executive Director
MedPAC