



Electronically submitted meetingcomments@medpac.gov

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April 21, 2021

Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW
Suite 701
Washington, DC 20001

Re: Medicare Indirect Medical Education Payment Adjustments

Dear Chairman Chernew:

I am writing on behalf of the Association of American Medical Colleges (AAMC or Association) to provide our perspective on the Medicare Payment Advisory Commission's (MedPAC or Commission) recent consideration of the creation of an outpatient Indirect Medical Education (IME) payment adjustment for the Medicare outpatient prospective payment system. We appreciate the Commission's recommendation that the Medicare outpatient payment system should include an IME adjustment to help offset the higher outpatient patient care costs at teaching hospitals. However, given the purpose of the inpatient IME which is essential to allowing teaching hospitals to maintain services to the most complex and vulnerable patients, and the overall negative Medicare margins for major teaching hospitals, we believe the payments for the outpatient IME adjustment should be in addition to the current level of inpatient IME payments.

From the discussions in October, March, and April we understand that the Commission's recommendation would be for an outpatient IME adjustment to be added but that total payments for both the inpatient and outpatient adjustments would not exceed the current total payment for the inpatient IME adjustment -- referred to as "budget neutral" in the discussions. Commission staff noted that this "budget neutrality" is appropriate because they believe Medicare overpays hospitals for indirect costs on the inpatient side as compared to the "empirical" level calculated by MedPAC.

While we appreciate that the Commission does not recommend reducing the current level of IME payments made to teaching hospitals, we disagree that the inpatient IME payment is overpaid (see below). As a result, we believe that additional dollars should be added for the outpatient IME. Moreover, the recommendation, which the majority of MedPAC Commissioners supported, does not mention budget neutrality, saying only that "Congress should require CMS to transition to empirically justified indirect medical education adjustments to both the inpatient and outpatient Medicare payments." As written, there is no suggestion that the total level of IME payments will remain the same. We recommend that this is addressed.

Our letter focuses on the following:

- The inpatient IME should not be reduced. The current inpatient IME payment adjustment is essential to the ability of teaching hospitals to treat the most vulnerable and complex Medicare patients and maintain critical stand-by and other services to all patients and their communities. Yet, even with this adjustment, Medicare margins at teaching hospitals remain negative.
- More work needs to be done to determine an appropriate proxy for increased patient acuity in teaching hospitals and adequate outpatient IME payment adjustment.

The Inpatient IME Adjustment Is A Critical Patient Care Payment for Teaching Hospitals

The Medicare program has long recognized and provided financial support to teaching hospitals for their roles which extend beyond the standard patient care services they provide. The IME adjustment reflects the unique patient care that teaching hospitals provide, including the types of patients treated and the services that are maintained by teaching hospitals.

Both inpatient and outpatient Medicare margins for teaching hospitals continue to be negative, and for many of these hospitals a significant change in payment structure could interfere with the patient driven mission of our members. MedPAC notes in its March 2021 Report to Congress¹ that teaching hospitals 2019 Medicare margins remain negative at **negative 8.7 percent**. An analysis done of federal fiscal year 2018 data by Vaida Health Consultants on behalf of the AAMC showed that overall, aggregate Medicare margins including DME and Health Technology payments are -11.6% for major teaching hospitals. Overall, aggregate outpatient Medicare margins excluding direct graduate medical education payments and costs are -24% for major teaching hospitals².

As proposed, redirecting inpatient IME dollars to fund the outpatient IME proposal would further exacerbate teaching hospitals negative Medicare margins, a consequence that some teaching hospitals may not be able to absorb, particularly safety net teaching hospitals.

An Outpatient IME Would Address the Current Underpayment of Teaching Hospitals in the Outpatient Setting but Additional Work Is Required

As MedPAC staff noted, teaching hospitals are underpaid for costs in outpatient settings, as demonstrated by their significant negative outpatient margins. As many commissioners noted, training residents in the outpatient setting can be labor intensive. That can be complicated in

¹ Medicare Payment Advisory Commission March 2021 Report to Congress: Medicare Payment Policy. March 15, 2021. http://medpac.gov/docs/default-source/reports/mar21_medpac_report_ch3_sec.pdf?sfvrsn=0

² Analysis by Vaida Health Consultants on behalf of AAMC. Data Source: Centers for Medicare and Medicaid Services, HCRIS Database, September 30, 2020 Update. Data covers fiscal year 10/1/2017 – 9/30/2018. Critical Access Hospitals and hospitals in Maryland and Puerto Rico are not included in the analysis. Cost reports with ratios of revenue to cost outside the interval of +/- three standard deviations from the geometric mean were not included in the calculation of aggregate statistics. Direct and Indirect Medical Education payments for managed care patients not included in the revenues used to calculate the margins.

hospital outpatient departments that tend to care for more medically complex patients who require additional time and attention during their visits. The current MedPAC proposal would use a hospital's resident-to-patient ratio across inpatient and outpatient settings; which is different from the current intern and resident-to-bed (IRB) ratio used for the inpatient IME adjustment. It is unclear how the resident-to-patient ratio will capture these nuances. The outpatient IME adjustment should be designed in such a way to accurately capture patient intensity and other patient-related costs to ensure an accurate outpatient IME adjustment.

If this change were to be made it is unclear where the data to develop the ratio is available; how would patients be counted? Would resident counts need to be changed to identify if a resident was in an inpatient setting, in an outpatient setting paid under the Outpatient Prospective Payment System (OPPS), or outpatient in a setting not paid under OPPS?

Residents Already Train in the Outpatient Setting

One of MedPAC's stated goals in recommending an outpatient IME adjustment is to foster greater residency training in the outpatient setting. However, residents already train in outpatient settings, in part to fulfill accreditation requirements of the Accreditation Council for Graduate Medical Education (ACGME) and in part because that is where more and more patients receive care. Residents' time in hospital outpatient departments is counted for in the inpatient IME adjustment.

The increase in resident training in the outpatient setting can also be attributed to overall changes in the healthcare system. For example, advances in technology and medicines enable more procedures to naturally migrate from inpatient to outpatient settings. We are already seeing this with the rise of complex procedures being successfully performed in outpatient settings, with many AAMC members at the forefront of this trend.

Further, as was noted during the March discussion about the outpatient IME proposal, outpatient care is very specialty-dependent so that a hospital's mix of residencies will be a major determinant of which residents receive more training in the outpatient setting. Of equal importance is the mix of patients that a hospital treats and the fact that many of the complex cases that residents must see in order to train need to be treated primarily in the inpatient setting.

Any Changes to IME Payment Policy Merit Congressional Oversight, An Understanding of the Impact of Such Changes, and Stakeholder Input

The AAMC we would be extremely concerned if CMS had the authority to develop IME payment policy without Congressional oversight, a firm understanding of the impact of any changes on teaching hospitals as well as the health care system as a whole, and a full consideration to stakeholder views.

CONCLUSION

Teaching hospitals are mission driven, community focused, and patient centric; this requires commitments to meeting the demands of training our future health care workforce while

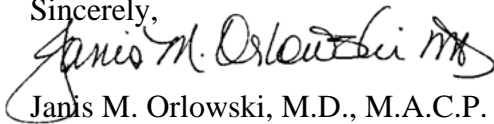
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providing high quality care and services that are not available elsewhere. Medicare has recognized that all of these activities incur costs, but even with the IME adjustment and other add-on payments, many teaching hospitals have negative Medicare margins, with some facing negative overall margins. Cuts to inpatient IME would further exacerbate these financial challenges. While the AAMC has long supported the creation of an outpatient IME payment adjustment, we believe it merits additional funding and should not be done by reducing the inpatient IME adjustment. As always, we appreciate the discussion and careful analysis by the MedPAC staff and the work of the commissioners. We will continue to work with MedPAC on this and other areas of extreme importance.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski" with a stylized flourish at the end.

Janis M. Orlowski, M.D., M.A.C.P.

Chief Health Care Office

cc: James E. Mathews, Ph.D.
MedPAC Executive Director