American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

September 30, 2019

Francis J. Crosson, M.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, N.W., Suite 701
Washington, DC 20001

Dear Dr. Crosson:

At its September 2019 meeting, the Medicare Payment Advisory Commission (MedPAC, or the Commission) discussed potential changes to the Indirect Medical Education (IME) program, which supports patient care and resident training at teaching hospitals. On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) asks that commissioners consider the following issues as they continue their discussions, each of which would have a significant impact on hospitals, health systems and the Medicare beneficiaries we serve.

Regarding the discussions during the September meeting on potential modifications to the Medicare IME program, we:

- Urge the Commission to give due consideration to teaching hospitals' essential function as a critical source of inpatient care provision and training. Financial support must be adequate to maintain and ensure high-quality inpatient care at these organizations.
- Urge the Commission to release a more granular assessment of the hospital-level impacts of its potential modifications, including any performance-based components. Substantial redistribution of IME payments would have significant consequences for teaching hospitals and the communities they serve.
- Are greatly concerned about any attempts to exacerbate Medicare underpayments even further – doing so is untenable and would limit hospitals' ability to provide state-of-the-art clinical care and train the next generation of practitioners.

PURPOSE OF MEDICARE'S MEDICAL EDUCATION PROGRAM

The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs for training health professionals – a strong physician workforce is clearly necessary to provide medical services to Medicare beneficiaries. Therefore, the program has financially supported Graduate Medical Education (GME) for several decades.

As the Commission has highlighted in previous work, teaching hospitals "have always had higher Medicare inpatient costs per discharge" compared to other hospitals. While some portion of this cost is due to direct costs of GME, other reasons for higher costs among teaching hospitals include: "unmeasured differences in patients' severity of illness, inefficiencies in the use of services associated with residents' learning by doing, and greater use of emerging technologies."[1] Higher costs associated with teaching hospitals are also driven by providing highly specialized care and maintaining significant standby capacity.[2] For example, 31% of major teaching hospitals maintain burn care units, 67% provide level 1 trauma services, and 78% provide neonatal intensive care unit care,[3] all of which involve high fixed costs and specific expertise that may not be available elsewhere.

The Medicare IME program was established to defray these "indirect" costs of the resident-training environment and, as a result, supports teaching hospitals in fulfilling their missions, which include both patient care and education.[4] IME payments are made as a percentage add-on to both operating and capital portions of the hospital's inpatient PPS payment per case. The add-on percentage varies based on the intensity of the hospital's teaching program (measured as the ratio of residents to hospital beds), and the number of residents included in the calculation of the resident-to-bed ratio is capped at 1996 levels.

CONSIDERATIONS FOR MEDPAC'S PROPOSED IME PROGRAM MODIFICATIONS

At the September meeting, MedPAC commissioners discussed possible changes to the IME program including: shifting some IME funds to the outpatient setting; eliminating capital IME payments; and reducing aggregate IME payments in order to shift some funds to a performance-based payment program. While total aggregate IME funds would remain the same, MedPAC acknowledged that there would be "substantial

---

[1] MedPAC. (2007). *Report to Congress: Medicare Payment Policy*. Accessed at: http://www.medpac.gov/docs/default-source/reports/Mar07_EntireReport.pdf.
[2] Koenig, L., Dobson, A., Ho, S., Siegel, J. M., Blumenthal, D., & Weissman, J. S. (2003). Estimating the mission-related costs of teaching hospitals. *Health Affairs, 22*(6), 112-122.
[3] AHA Annual Survey of Hospitals, 2017. Teaching hospitals are from the CMS FY2020 IPPS impact file. Major teaching hospitals are defined as teaching hospitals with 100 or more residents.
[4] The Direct GME program helps to fund the teaching costs of residency programs, such as resident salaries and benefits, faculty salaries and benefits, and administrative overhead expenses. Payments are based on a hospital-specific, per-resident cost in 1984, updated annually for inflation. The per-resident payment amount varies by the residents' specialties, and the resident count for most hospitals also capped at their 1996 levels.

distribution of IME payments" and that many teaching hospitals would see "material changes" in their IME payments. This redistribution would also have significant impacts on hospitals' total Medicare margins.

We appreciate MedPAC's recognition that more care is shifting to the outpatient setting. At the same time, we agree with Commissioner Warner Thomas' observation that inpatient care remains central to academic medical centers' work. In fact, MedPAC noted in its March 2018 Report to Congress that major teaching hospitals saw the largest *increase* in inpatient surgeries among all hospital categories.[5] AHA data also demonstrate the capacity of teaching hospitals to provide inpatient care; in 2017, not only did they account for 58% of inpatient admissions overall, but also they saw increases in inpatient admissions during the previous 5 years while nonteaching hospitals experienced decreases.[6] Commissioner Thomas also reiterated that teaching hospitals play a critical role in receiving transfer patients from other providers that may not have the staff or resources to adequately address high-acuity cases. A recent policy brief by the Association of American Medical Colleges found that, while teaching hospitals represent less than a third of inpatient PPS hospitals, they take on roughly 80% of transfer cases, which are more medically complex and resource-intensive.[7] As a result, the value of inpatient care provided by these hospitals extends far beyond their immediate communities. **Thus, financial support should be adequately maintained to ensure high-quality inpatient care at these institutions. We urge the Commission to give due consideration to teaching hospitals' essential function as a critical source of inpatient care provision and training.**

We also share concerns expressed by several commissioners related to the variable – and meaningful – financial impact of the proposed IME program changes on teaching hospitals. During the meeting, MedPAC staff noted that fully 20% of teaching hospitals could see as much as *a 25% decrease* in their IME payments. It was indicated that a number of hospitals could experience *a 5% or more decrease* in their total Medicare payments due to the proposed changes. Yet, the characteristics of those hospitals remain unknown; the hospitals that stand to see large decreases may very well be those that provide the most highly specialized care or serve the most complex, vulnerable patients. **As requested by several commissioners, a more granular assessment of the hospital-level impacts is needed in order to fully understand what any modifications to the IME program – including any performance-based components – would mean for teaching hospitals and the communities they serve.**

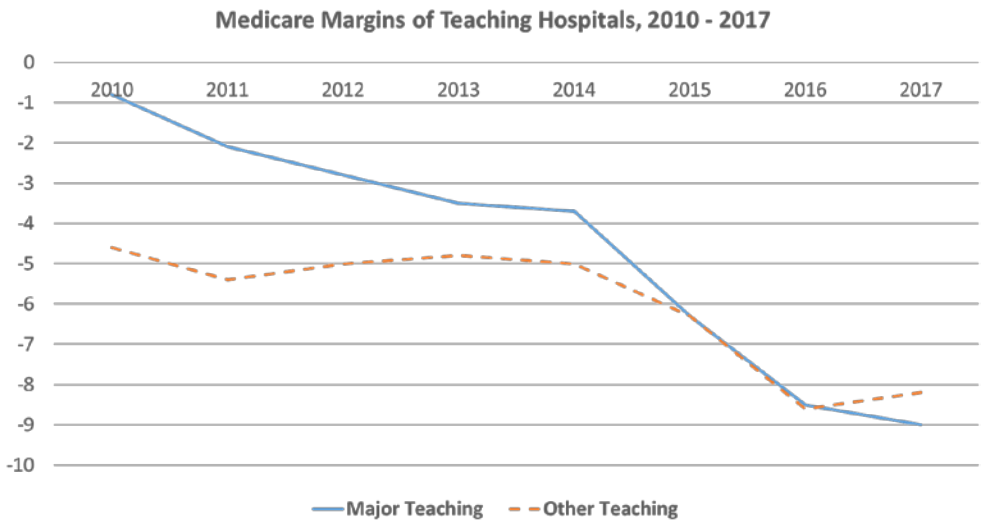
---

[5] MedPAC. (2018). *Report to Congress: Medicare Payment Policy.* Accessed at: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch3_sec.pdf?sfvrsn=0

[6] AHA Annual Survey of Hospitals, 2012-2017. Teaching hospitals are from the CMS FY2020 IPPS impact file.

[7] AAMC. (2019). *Analysis in brief: Teaching Hospitals Are Critical Providers of Care for Medicare Hospital Transfer Patients.* Accessed at: https://www.aamc.org/system/files/2019-07/june2019teachinghospitalsarecriticalprovidersofcareformedicareh.pdf

Decreases to Medicare payments of the magnitude discussed during the meeting could compromise the financial stability of teaching hospitals. According to MedPAC's March 2019 report, in 2017, major teaching hospitals had an overall Medicare margin of *negative 9.0%*. Moreover, margins for both major and other teaching hospitals have been negative and on the decline for nearly a decade, as shown below.



Exacerbating Medicare underpayments even further is untenable and would limit hospitals' ability to provide state-of-the-art clinical care and train the next generation of practitioners. Now, more than ever, an adequate margin is needed to keep pace with new life sustaining advances in medicine, evolving needs and preferences among patients and communities, and investments in new payment and delivery models. We, therefore, agree with Commissioner Pat Wang's recommendation that MedPAC be "very sensitive about any impact on both [Medicare and all-payer margins] and the viability of access to Medicare beneficiaries to excellent teaching hospitals."

We thank you for your consideration of our comments. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, senior associate director of policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development