What the Election Means for Academic Medicine and Teaching Hospitals

Academic Medical Centers Program
AHLA

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Chief Public Policy Officer
January 24, 2013

Since the Election...

• Jan. 1: American Taxpayer Relief Act of 2012 (H.R. 8) approved:
  o Short term SGR fix until December 2014
    ▪ 26.5% Medicare pay cut for physicians avoided ($26.5B/10 yrs cost, CBO)
  o Sequestration pushed off until March 2013

• Jan. 3: 113th Congress convened

• Jan. 21: Presidential Inauguration
## About Half of Chairmen Will Keep Their Posts

### Majority Party Positions

**Speaker of the House**
- John Boehner R-Ohio
  - Speaker since 2010, likely unchallenged
  - Conservative voter
  - Pledged to work with Obama after reelection to avoid fiscal cliff

**Majority Leader**
- Eric Cantor R-Va.
  - Elected to House in 2000
  - Served as House Minority Whip, then became House Majority Leader in 2011 at start of 112th Congress
  - First elected to House in 2006
  - Appointed as Chief Deputy Whip in 2009, became Majority Whip in 2011 at start of 112th Congress

**Majority Whip**
- Kevin McCarthy R-Calif.

### Committee Chairmen Positions

<table>
<thead>
<tr>
<th>Committee</th>
<th>Chairman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>Frank Lucas R-Okla.</td>
</tr>
<tr>
<td>Oversight and Government Reform</td>
<td>Darrell Issa R-Calif.</td>
</tr>
<tr>
<td>Appropriations</td>
<td>Harold Rogers R-Ky.</td>
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<tr>
<td>Small Business</td>
<td>Sam Graves R-Mo.</td>
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<td>Armed Services</td>
<td>Buck McKeon R-Calif.</td>
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<tr>
<td>Veterans’ Affairs</td>
<td>Jeff Miller R-Fla.</td>
</tr>
<tr>
<td>Education and Workforce</td>
<td>John Kline R-Minn.</td>
</tr>
<tr>
<td>Ways and Means</td>
<td>Dave Camp R-Mich.</td>
</tr>
<tr>
<td>Permanent Select</td>
<td>Mike Rogers R-Mich.</td>
</tr>
<tr>
<td>Intelligence</td>
<td></td>
</tr>
</tbody>
</table>

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## Next:

- **Feb. 4:** President submits budget to Congress
- **Late February:** Federal debt reaches statutory limit
- **Mar. 1:** White House releases sequester report and orders cuts
- **Mar. 27:** Sequestration takes effect & Continuing Resolution (CR) expires
President’s FY 2013 Budget—
Academic Medicine Vulnerable

- GME Cuts: $9.7B/10 yrs
- Phase-Down Bad Debt Payments: $35.9B/10 yrs
- Strengthen IPAB: (no budget impact)
- Single Blended FMAP Rate: $17.9B/10 yrs
- Phase-Down Medicaid Provider Tax: $21.89B/10 yrs
- Rebase Medicaid DSH Allotments: $8.3B/10 yrs

President’s Medicare Savings
& GME

- Increased “Value” – GME Cuts: $9.7B/10 years
  - “Gradually reduce” IME payments by 10% (2014)
  - “Partially correct” the “imbalance” (identified by MedPAC) between current IME payments and actual patient care costs to teaching hospitals
  - HHS Secretary has authority to “set standards” for teaching hospitals that:
    - Encourage training of primary care residents
    - Promote high-quality and high-value health care delivery
A Note about GME...

1. Direct Graduate Medical Education (DGME) Payments—*Resident Training*
   - Partially “reimburse[s] teaching hospitals for Medicare’s share of the costs of salaries and fringe benefits paid to residents, interns, and teaching faculty, and certain overhead costs relating to teaching activities.” *U.S. Congress, 1999*

2. Indirect Medical Education (IME) Payments—*Patient Care*
   - Percentage add-on reimbursement to the basic per-case (MS-DRG) payment paid to teaching hospitals

*Medicare DGME and IME support capped since 1996*

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**Medicare Covers 21% of Direct Teaching Costs (DGME)**

- There are ~108,000 trainees.
- The average DGME cost per trainee was $143,000.
- Medicare based its reimbursement on a $101,000 PRA.

*Source: HCRIS 9/30/2012 Release*
**IME is a Patient Care Payment with An “Education” Label**

Created because of concerns about the inability of Medicare coding to “account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents”

(House Ways & Means Committee Rept., No. 98-25, March 4, 1983 and Senate Finance Committee Rept., No. 98-23, March 11, 1983 [emphasis added]).

“to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals.”

U.S. Congress, 1999

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**Level I Trauma Center Requirements**

*Examples of Associated Costs*

**Clinical Service Costs Alone**

- *Minimum* 1200 trauma admissions annually
- 24/7 in-hospital trauma surgeon and anesthesiologist
- 24/7 *immediate access* to complete operating room team (team cannot be dedicated to other functions in the hospital)
- 24/7 in-hospital surgical ICU physician
- 24/7 in-hospital radiology staff
- 24/7 in-hospital clinical lab services
- 24/7 access *within 15 minutes* to a board certified: cardiac surgeon; hand surgeon; neurosurgeon; orthopedic surgeon; microvascular/replant surgeon; OB/GYN surgeon; eye surgeon;; oral/maxilllofacial surgeon; plastic surgeon; thoracic surgeon; critical care physician; radiologist
Level I Trauma Center Requirements

Examples: Education and Research Requirements are Mandatory

- Maintain a trauma fellowship and/or trauma-focused residency training programs in related specialties
- Offer educational programs for providers not affiliated with the trauma center
- Maintain a trauma registry
- Conduct research that investigates issues related to trauma, trauma care, and trauma prevention

Level I Trauma Center Requirements

In 2002, “total mission-related costs for U.S. teaching hospitals were slightly more than $27 billion.”

Medicare’s Investment in GME

![Graph showing the percentage of Medicare's investment in Graduate Medical Education (GME) over the years 1998 to 2009. The graph includes two lines, one for Direct Graduate Medical Education (DGME) and one for Indirect Medical Education (IME), both as percentages of Medicare.]

**SOURCE:** AAMC Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary; Medicare Cost Reports (June 30, 2012 release)

Current Reality about AMC Missions

- **Education**
  - UME costs (complex) higher than tuition
  - Medicare Direct GME $3B (out of $13B)

- **Clinical Care**
  - Average COTH Medicare margin about—3%
  - Medicaid losses higher
  - COTH provides $8 billion charity care/yr
  - No explicit payments for standby care
  - Many clinical service lines lose money

- **Research**
  - NIH, other grants don’t pay full costs
Missions Are Inter-Related & Subsidized by Clinical Revenue

Flow of Funds in AMCs...

Flow of Funds in AMCs... (con’t)

What Is Driving These Trends?

- Some academic specialties cannot fund competitive salaries based on professional billings alone
  - Ancillary revenues in the private sector
  - Distinctive nature of academic practice
  - Increased demand for faculty physician administrative time
  - Growth in the educational enterprise
  - Mandates from RRCs
  - Increasing use of small group teaching approaches
    - Residents and fellows over the cap
  - Growing new expense categories
    - On-call pay
    - Advanced Practice Providers
  - Other strategic or mission related initiatives
    - Recruitment of chairs and high profile faculty members
    - Indigent care funding reconciliation
    - Margin sharing arrangements


### Chart 6-12. Medicare inpatient payments, by source and hospital group, 2009

<table>
<thead>
<tr>
<th>Hospital group</th>
<th>Base</th>
<th>IME</th>
<th>DSH</th>
<th>Outlier</th>
<th>Additional rural hospital*</th>
<th>Total payments (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All hospitals</td>
<td>81.1%</td>
<td>5.0%</td>
<td>9.4%</td>
<td>3.6%</td>
<td>1.0%</td>
<td>$110,019</td>
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<tr>
<td>Urban</td>
<td>80.5</td>
<td>5.5</td>
<td>9.8</td>
<td>3.9</td>
<td>0.3</td>
<td>96,622</td>
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<tr>
<td>Rural</td>
<td>85.7</td>
<td>0.7</td>
<td>5.4</td>
<td>1.2</td>
<td>7.0</td>
<td>11,396</td>
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<tr>
<td>Large urban</td>
<td>78.8</td>
<td>6.6</td>
<td>10.3</td>
<td>4.2</td>
<td>0.1</td>
<td>57,018</td>
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<tr>
<td>Other urban</td>
<td>82.8</td>
<td>3.9</td>
<td>9.2</td>
<td>3.5</td>
<td>0.7</td>
<td>41,604</td>
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<tr>
<td>Rural referral</td>
<td>80.1</td>
<td>1.1</td>
<td>7.9</td>
<td>2.0</td>
<td>0.0</td>
<td>3,173</td>
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<tr>
<td>Sole community</td>
<td>81.9</td>
<td>0.9</td>
<td>5.4</td>
<td>1.2</td>
<td>7.0</td>
<td>11,396</td>
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<tr>
<td>Medicare dependent</td>
<td>65.2</td>
<td>0.0</td>
<td>7.8</td>
<td>1.1</td>
<td>5.9</td>
<td>1,420</td>
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<tr>
<td>Other rural &lt;50 beds</td>
<td>91.5</td>
<td>0.2</td>
<td>7.3</td>
<td>1.1</td>
<td>0.0</td>
<td>262</td>
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<tr>
<td>Other rural &gt;50 beds</td>
<td>90.6</td>
<td>0.4</td>
<td>7.0</td>
<td>2.0</td>
<td>0.0</td>
<td>1,501</td>
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<tr>
<td>Voluntary</td>
<td>81.6</td>
<td>5.3</td>
<td>8.5</td>
<td>3.6</td>
<td>1.0</td>
<td>80,072</td>
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<tr>
<td>Proprietary</td>
<td>84.3</td>
<td>1.3</td>
<td>11.1</td>
<td>2.9</td>
<td>0.5</td>
<td>15,418</td>
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<td>Government</td>
<td>74.6</td>
<td>7.0</td>
<td>12.5</td>
<td>4.3</td>
<td>1.6</td>
<td>14,528</td>
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<tr>
<td>Major teaching</td>
<td>66.3</td>
<td>16.1</td>
<td>12.2</td>
<td>5.3</td>
<td>0.1</td>
<td>24,756</td>
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<tr>
<td>Other teaching</td>
<td>83.0</td>
<td>3.7</td>
<td>9.3</td>
<td>3.4</td>
<td>0.6</td>
<td>40,191</td>
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<tr>
<td>Non-teaching</td>
<td>87.4</td>
<td>0.0</td>
<td>7.9</td>
<td>2.8</td>
<td>1.9</td>
<td>45,072</td>
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</table>

MedPAC June 2011
FY10 Hospital Outlays Cut by 3%, 5%... in millions...

<table>
<thead>
<tr>
<th></th>
<th>FY10</th>
<th>-3%</th>
<th>-5%</th>
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</thead>
<tbody>
<tr>
<td>Res &amp; Fellows</td>
<td>$22.4</td>
<td>$21.73</td>
<td>$21.28</td>
</tr>
<tr>
<td>MedDirs</td>
<td>$14.2</td>
<td>$13.77</td>
<td>$13.49</td>
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<tr>
<td>Dept Supp</td>
<td>$41.8</td>
<td>$40.55</td>
<td>$39.71</td>
</tr>
<tr>
<td>Total</td>
<td>$78.4</td>
<td>$76.05</td>
<td>$74.48</td>
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</table>

Where to cut $2.35M or $3.92M?

**Deficit Reduction Debate & GME**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Cuts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simpson/Bowles (bipartisan) (2010)</td>
<td>Cut GME by 60%</td>
</tr>
<tr>
<td>&quot;Fix the Debt&quot;/Simpson/Bowles II (bipartisan) (2012)</td>
<td></td>
</tr>
<tr>
<td>Sen. Conrad (D-ND, Budget Committee Chairman) (2012)</td>
<td></td>
</tr>
<tr>
<td>Rep. Ryan (R-WI, Budget Committee Chairman) (2012)</td>
<td></td>
</tr>
<tr>
<td>BCA (Sequestration) (2011)</td>
<td>Cut GME by 2%</td>
</tr>
<tr>
<td>Biden Negotiations Team (bipartisan) (2011)</td>
<td>Cut GME by 15%</td>
</tr>
<tr>
<td>Super Committee (bipartisan) (2011)</td>
<td>Cut GME by 15%-60%</td>
</tr>
<tr>
<td>Senate Gang of Six (bipartisan) (2011)</td>
<td></td>
</tr>
<tr>
<td>President Obama FY 2013 Budget Proposal (2012)</td>
<td>Cut GME by 16% (CHGME by 60%)</td>
</tr>
<tr>
<td>President Obama Deficit Reduction Plan (2011, 2012)</td>
<td></td>
</tr>
<tr>
<td>Sen. Corker (R-TN) (2012)</td>
<td>Cut GME by $50 Billion over 10 Years</td>
</tr>
<tr>
<td>CAP (2012)</td>
<td>Cut GME by $28 Billion over 10 years</td>
</tr>
<tr>
<td>CBO Choices for Deficit Reduction (2012)</td>
<td>Cut $10 Billion annually by 2020 (consolidate and reduce federal payments to teaching hospitals)</td>
</tr>
<tr>
<td>President Obama Offer During Fiscal Cliff Negotiations (11/29/12)</td>
<td>Cut $400 Billion in Medicare/entitlement payments (to be determined)</td>
</tr>
<tr>
<td>Republican Offer During Fiscal Cliff Negotiations (12/3/12)</td>
<td>Cut $600 Billion in health spending determined (to be determined)</td>
</tr>
</tbody>
</table>

**IME Cut Impact: 1 member est.**

- 8% reduction in staffing that would equal approx 385 FTEs or $25M
- Reduce residency programs by 75-100 residents
- Further reduce or close Mental Health services and other services with low or negative contribution margins e.g. the burn unit
- Decrease access to select ambulatory services, such as sickle cell, geriatric, coagulation clinics, CHF clinics etc.
- Decrease access to transfers from surrounding community hospitals seeking specialized service
- Reductions in research support
Health Care Reform vs. Hospital & Provider Cuts

- Medicare/Medicaid cuts to hospitals = $155 B/10 yrs
- Hospital price transparency
- Community benefit reporting requirements/IRS
- Readmissions policies FY 2013
- Value based purchasing FY 2013
- Medicaid voluntary expansion CY 2014
- Exchange establishment (fed/state) CY 2014
- Hosp Acquired Conditions reductions FY 2015
- Will coverage levels be adequate (96%)

DSH/IME Cuts Alone...

<table>
<thead>
<tr>
<th>Example AMC in:</th>
<th>(Actual) 50% Cut in DSH Payments</th>
<th>(Proposed) 60% Cut in IME</th>
<th>Total Cuts</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>$7,770,641</td>
<td>$26,895,266</td>
<td>$34,665,907</td>
</tr>
<tr>
<td>Illinois</td>
<td>$11,761,419</td>
<td>$15,436,920</td>
<td>$27,198,339</td>
</tr>
<tr>
<td>New York</td>
<td>$3,252,557</td>
<td>$24,393,445</td>
<td>$27,646,002</td>
</tr>
<tr>
<td>North Carolina</td>
<td>$10,362,557</td>
<td>$18,517,455</td>
<td>$28,880,012</td>
</tr>
<tr>
<td>Texas</td>
<td>$6,968,139</td>
<td>$6,976,773</td>
<td>$13,944,912</td>
</tr>
</tbody>
</table>

But add other budget proposals….and cuts to be implemented.
Estimated Losses for All Major Teaching Hospitals ACA Implementation & Budget Cuts

Voluntary Medicaid Coverage Expansions 2014

Source: FY2013 Medicare Final Impact File
Fighting Medicaid Expansion

States Most Reluctant to Expand Have Lower Enrollment in Current Programs

Comparison of Medicaid Participation Rates and Likely Medicaid Expansion, By State

Key
Medicaid Participation Rate
- 50% or lower Medicaid participation rate among eligibles
- 50-59.9% Medicaid participation rate among eligibles
- 60-69.9% Medicaid participation rate among eligibles
- 70% or higher Medicaid participation rate among eligibles

Medicaid Expansion Participation
- State not participating— or leaning toward not participating— in the ACA Medicaid expansion
State Decisions on Health Care Exchanges

- Opting for a federally run exchange
- Opting for a state run exchange
- Opting for a partnership exchange

ACA Physician Issues on Horizon

- Changes to geographic adjusters in payment
- Quality reporting mandatory for physicians
  - Physician pay ‘value’ modifier
- Public reporting (‘physician compare’)
- Medicaid payment rates
  - 2013-14: Rates not lower than Medicare for primary care services (proposed rule)
- What to do about the SGR
- Medicare payments
  - 2011-15: bonuses to pc practitioners and general surgeons
**Physician Payments Cuts (HOPD)**

For many services, Medicare has different payment rates to physicians based on the site of service

- “Office” or “Non-Facility”
  - Physician payment higher
  - Physician responsible for rent, other practice expenses
- “HOPD” or “Facility” or “Provider-Based”
  - Physician payment lower – (fewer expenses)
  - Hospital can submit a separate bill for facility costs
  - Total payment (physician + hospital) higher

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**Hospital Outpatient Department (HOPD) E/M Cuts - MedPAC**

**January 2012 – MedPAC formally adopted a recommendation**

"...reduce payments for evaluation and management office visits provided in outpatient departments so that total payment rates for these visits are the same in an outpatient department for physician office...."  
(MedPAC Report March 2012)

- Phase transition over 3 years
- Limited stop loss for hospitals with DSH patient percent at or above median (@25%)
- Study by 2015 to examine impact on access for low-income patients
- Greatest impact on major teaching and nonprofit hospitals
### MedPAC Proposal

**99213 - Midlevel Established Patient Visit**

<table>
<thead>
<tr>
<th>Fees*</th>
<th>Physician Office</th>
<th>HOPD</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$68.97</td>
<td>$49.27</td>
<td>($19.70)</td>
</tr>
<tr>
<td>Hospital Fee</td>
<td>N/A</td>
<td>$75.13</td>
<td>+$75.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$19.70</td>
<td>+$19.70</td>
</tr>
<tr>
<td>Total</td>
<td>$68.97</td>
<td>$124.40</td>
<td>+$55.43</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$68.97</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Fees based on national 2011 rates and include patient copay.

74% reduction to hospital payment

### Distribution of Medicare E/M Visits

**E/M Visits**

- **Office**: 93%
- **HOPD**: 7%

**Teaching Status**

- Non 30%
- Minor 24%
- Major 45%

**DSH Patient Percent**

- >=25%: 57%
- 11.75 - 25%: 31%
- < 11.75%: 8%
- No DPP* 4%

Source: The Moran Analysis of 2010 5% Medicare Standard Analytic File

*No DPP refers to hospitals with zero DSH payment or missing DSH payment data
HOPD Visits Treat Higher Risk Patients and Serve More Vulnerable Patient Populations

Source: The Moran Analysis of 2010 5% Medicare Standard Analytic File; risk score based on HCC model

Major Teaching Hospitals Serve Proportionately More Vulnerable Patients

Source: The Moran Analysis of 2010 5% Medicare Standard Analytic File
Total OPPS Payment Losses for E/M Visits—69% Faced by Teaching Hospitals

- National* Reduction in OPPS Payments
  - All hospitals: ~ $1.07 Billion
  - Teaching Hospitals: ~ $740 Million
  - Major Teaching Hospitals: ~ $454 Million (45%)
  - All Hospitals with DPP>25%: ~$621 Million

*Excluding MD & PH
Source: The Moran Analysis of OPPS 2013 rate setting file
Upcoming Regulations

From existing guidance*, the AAMC anticipates upcoming regulations to include:

• Guidance on essential health benefit implementation in Medicaid
• Further comment to consider amending the final rules regarding Medicaid eligibility determinations made by Exchanges
• QHP quality reporting requirement and quality reporting and disclosure requirements for all Exchanges
• Draft and final notice of benefit and payment parameters including user fee, risk adjustment, risk corridor, and reinsurance methodologies

* Essential Health Benefits Bulletin (12/16/11) and Federally-Funded Exchange Guidance (5/16/12); current regulations available at http://cciio.hhs.gov/resources/regulations/index.html#hie

Sequestration Threat Déjà Vu in March 2013

• Reductions up to:
  o $720 million/yr COTH IPPS payments
  o $250+ million/yr practice plan payments
  o $1.5 billion/yr to NIH funding to institutions
  o Up to 14% reduction in other discretionary
  o Medicare cuts limited to 2% for “services rendered”
Bottom Line for Academic Medicine:

Can clinical care revenue continue to support medical education and research?

And if not, which programs would we eliminate…to suffer which long term outcomes of lacking services and innovation?