NAUH
NATIONAL ASSOCIATION OF URBAN HOSPITALS

October 7, 2015

Rep. Kevin Brady
Chairman
House Ways and Means Committee Health Subcommittee
301 Cannon Building
Washington, DC 20515

Dear Chairman Brady:

I am writing on behalf of the National Association of Urban Hospitals (NAUH), a group of private, non-profit urban safety-net hospitals, to convey our views on a bill you are sponsoring: H.R. 3292, the Medicare IME Pool Act of 2015.

NAUH appreciates both the time and effort that you and the subcommittee have invested in improving the Medicare IME program and the inclusive process you have employed for doing so. We appreciated your willingness to share your Medicare improvement ideas late last year through your discussion draft and the opportunity you gave interested parties to comment on those ideas. Your staff has been generous with its time in talking to and meeting with us to discuss our concerns and explain some of the concepts in greater detail.

NAUH has a number of concerns about the IME proposal, the most important of which is that by making Medicare IME payments periodic lump-sum payments rather than Medicare add-on payments, as they are today, the proposal would effectively separate Medicare costs from Medicare IME payments. While NAUH recognizes that this reflects a desire to protect Medicare IME payments because in the future a greater proportion of Medicare services will be provided on an outpatient rather than an inpatient basis, through observation care, through managed care, and perhaps through other innovative service delivery models, we disagree with this approach for a number of reasons.

Medicare IME payments are reimbursement to hospitals for training medical residents and for the care those residents provide to patients. They are made based on the level of teaching intensity at hospitals, as measured by the ratio of residents to beds and the sheer volume of Medicare patients these residents serve. The proposed approach, however, would create a single, uniform payment rate that would be paid to every eligible teaching hospital for every individual medical resident, regardless of the teaching intensity and regardless of how many Medicare patients those residents treat. In addition, this single, uniform payment would not reflect variations in recipient hospital costs, such as area wages and case mix/patient severity – some hospitals, and especially, from NAUH's perspective, large urban safety-net hospitals, care for much sicker patients who require much more intensive treatment than the typical American hospital.

This would bring about fundamental change in the nature of the IME program – change we do not believe was intended and for which we are aware of no public policy rationale. Under H.R. 3292, significant sums of Medicare IME money would be taken away from hospitals that train large numbers of medical

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residents who serve large numbers of Medicare patients, including large numbers of low-income Medicare patients, and be redistributed to hospitals that train far fewer residents who serve far fewer of those patients.

Medicare IME payments also are intended to support highly specialized medical services that the typical hospital does not offer – services such as burn and trauma units and specialized stroke centers – so these hospitals can train our next generation of physicians in how to deliver these services. Reducing IME payments to the very hospitals that offer these services while training those physicians threatens both the viability of those services, which typically benefit patients from far beyond the boundaries of such hospitals' general geographic markets, as well as the training of physicians who, at the end of their residencies, will be fanning out across the country to establish their medical practices and serve new communities.

The typical large, private, non-profit urban safety-net hospital is a teaching hospital, and these hospitals would be devastated by the changes proposed in H.R. 3292. The vast majority of them would lose money, many would lose millions of dollars, and some of them would lose tens of millions of dollars a year. These are, moreover, the very hospitals NAUH believes we should want to support: they have outstanding medical education programs, they train large numbers of doctors, they offer sophisticated medical services that leave their residents superbly qualified to provide care throughout the country when their residencies are over, and most important, they treat large numbers of Medicare and low-income Medicare and other low-income and uninsured patients with significant help from their medical residents. NAUH believes these programs need and deserve Medicare's support and do not deserve to suffer significant reductions in Medicare support for their medical education programs.

NAUH also is concerned about an unintended consequence of H.R. 3292. Medicare IME is an added cost per case for hospitals, part of their reimbursement per claim structure, and many things are tied to that structure and what Medicare pays hospitals – most notably, contracts and rate agreements with both public and private insurers. Severing the relationship between Medicare costs and Medicare IME payments would greatly complicate the negotiation of such agreements, and we believe this challenge should be addressed before moving ahead with legislation.

We appreciate the opportunity to present our perspective on H.R. 3292 and welcome any questions you may have about the views we have respect and the reasoning behind them.

Sincerely,

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Executive Director