



National Association of
Children's Hospitals

401 Wythe Street
Alexandria, VA 22314
(703)684-1355 Fax (703)684-1589

N.A.C.H. FAX

DATE: 12/17/98

PAGES (including cover page): 3

TO: Chris Jennings
Domestic Policy Council

FAX: (202) 456-5557

PHONE: (202) 456-5560

FROM: Peters D. Willson
Vice President for Public Policy
Phone: 703-684-1355
Fax: 703-684-1589
E-mail: pwillson@nachri.org

SUBJECT: Chris -

Attached is a letter from Reps.

Mockley, Dingell, and Stark

in support of me in the

FY 2000 budget for children's

Hospitals.

If there are any transmission problems with this fax, please call me at 703-684-1355.

P.S. Rep. Dingell and Gjednessen also are
calling Jack Reier.

Pete

Congress of the United States
Washington, DC 20515

December 14, 1998

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

As you prepare for your fiscal year 2000 budget, we are writing to request the inclusion of funding for graduate medical education for our country's independent children's hospitals. As you know, these 53 institutions do not share a provider number with another larger adult institution for purposes of billing Medicare. As a result, they receive little to no support from Medicare for their teaching programs.

We are committed to recognizing and supporting the public good that all teaching hospitals provide through their graduate medical education (GME) programs, a commitment that needs to be maintained through any reforms considered to assure future stability to the Medicare program. We also must move forward with providing some form of federal GME support for these few children's hospitals, on an interim basis now and as part of any larger reform.

Medicare has increasingly become the one reliable source of GME support for teaching hospitals, as the competitive market has made it almost impossible to recover those costs from private payers. Medicaid in some states provides some support for the direct costs of GME, but this varies from state to state, particularly as states move to Medicaid managed care. The result has been a serious competitive disadvantage for all of these children's hospitals, as other teaching hospitals received \$76,000 per resident on average from Medicare in 1996 and they received \$400.

Many of these children's hospitals are experiencing losses on patient operations which are heavily attributable to GME. The lack of GME support exacerbates the competitive challenges they also face as safety net institutions and regional tertiary care centers. Medicaid, even with disproportionate share payments, on average, covers only 85 percent of the costs of caring for the children it covers in these institutions. And, Medicaid and private payer rates only rarely account for the higher costs of caring disproportionately for children with more severe and more chronic illnesses.

Of these 53 children's hospitals, 43 have significant GME programs. They represent less than one percent of all teaching hospitals; but they train five percent of all residents, almost a third of all pediatric residents, and the majority of all pediatric specialists. They also provide required pediatric rotations for many other residents. The hospital, teaching hospital and pediatric communities have joined the National Association of Children's Hospitals in recognizing the

Academic Health Centers: Exploring a Financial Paradox

Policymakers and leaders of medical schools and teaching hospitals have voiced grave concerns about the future survival of these institutions in a competitive health care system where the educational and research missions increase their costs.^{1,2,3} Yet the available data and standard measures of financial performance suggest that, on average, medical schools and teaching hospitals were financially healthy at least through the mid 1990s. At the same time their educational and research missions do not appear to have suffered.^{4,5} This creates something of a financial paradox: how have AMCs been able to maintain their financial viability and social missions while incurring the higher costs^{6,7} associated with research and education and the reported unwillingness of private payers to pay some or all of these incremental costs.³ This analysis, using work performed for the Secretary's Task Force on the Future of Academic Health Centers,⁸ attempts to explore possible reasons for the paradox and draws attention to the deficiencies in the available data that allows policymakers to measure the financial health and maintenance of social mission of academic health centers.

Definition of Academic Health Center

The Association of Academic Health Centers (AAHC) defines an AHC as a medical school and affiliated hospital that may or may not be owned by the university and one or more other health professions schools, including public health, nursing, dentistry, pharmacy, optometry, veterinary medicine and allied health. There are 105 AHCs listed in the Association of Academic Health Center (AAHC) 1996-1997 directory. The Association of American Medical Colleges (AAMC) defines an "integrated academic medical center hospital" to be one of the 118 institutions in the United States that comprise a medical school and a hospital where a majority of the clinical chiefs of service are also department chairs in the affiliated medical. Other organizations and researchers use slightly different definitions of AHCs.⁹

Because researchers and policymakers use varying definitions of AHCs, comparing empirical results across multiple studies is difficult. Whenever possible we will utilize studies that focus on approximately 100-120 major teaching hospitals and all of the allopathic medical schools although we sometimes rely on studies which use broader definitions of the relevant universe of teaching hospitals. We will place less emphasis on studies which examine osteopathic medical schools; the other components of AHCs, such as nursing or public health schools; or hospitals that have teaching programs but do not meet the AAHC or AAMC criterion of an AHC hospital. We also have not analyzed data on children's hospitals which train the majority of pediatric residents in the United States. While these entities are critically important to the United States health care system, they are

not the entities that have received the most public policy attention in recent years and are not the entities perceived to be financially precarious at the present time.

Incremental Costs of AHCs

The Commonwealth Fund Task Force on Academic Medical Centers estimates the incremental cost of providing medical education, conducting biomedical research, delivering highly specialized services and pursuing continuous patient care innovation in the 118 hospitals affiliated with AHCs at 8.1 billion dollars in 1997.⁵ Their estimate of the total cost of providing these services in all approximately 1200 teaching hospitals is 18 billion dollars. This estimate does not include the uncompensated care cost of the patient care services which are provided as part of routine medical care. It also does not include any higher patient care costs in medical schools and faculty practice plans resulting from the research and education missions. We did not encounter any published studies which estimated the incremental cost of education and research on medical schools or faculty practice plans.¹¹

While it is generally recognized that teaching hospitals perform a variety of functions in addition to patient care, there is some disagreement over how to estimate the incremental costs of research, education and patient care and their precise level. It is impossible for accountants or hospital managers to go into an AHC and identify the incremental costs associated with research, education or any of the other factors. Instead, the task of estimating the incremental cost is generally left to health economists who use regression analysis to estimate hospital cost functions. The specification and functional form of the econometric model can influence the estimated cost of each of the services

provided by AHCs and therefore the incremental cost associated with being an AHC. There are, for example, many different ways to measure teaching status, research intensity and the provision of standby and specialized services. How the measures are specified and what other factors are in the equation determines the estimated incremental cost of each factor and therefore the total incremental cost associated with education, research and specialty services.

For the purposes of this paper, we will assume that the Commonwealth Fund Task Force's estimate of 8.1 billion dollars is correct. After adjusting for the overall increase in health care spending, the estimate is similar to the number generated by the Clinton Administration during the 1993 health care reform debate and similar to earlier published estimates after adjusting for changes in overall levels of health care spending.^{6,12,13,14} In addition, the methodology that was employed to generate the Commonwealth Fund Task Force estimate is similar to the methods employed by previous studies.

Funding of AHCs

A large proportion of AHC revenues are from patient care services. Clinical services represent 90 percent of hospital revenues, 84 percent of faculty practice plan revenues and 47 percent of medical school revenues.⁷ These are the revenues that are considered the most vulnerable in light of the recent changes in the health care financing and delivery system and they are the primary focus of this analysis. First, we examine the sources of revenues for AHC hospitals and then for medical schools.

Funding from the Medicare Program

In 1994-95, 29 percent of the revenues of AHC hospitals were from the Medicare program.⁷ In fiscal year 1997, Medicare payments for direct and indirect medical education totaled an estimated \$6.8 billion.¹⁵ AHCs receive approximately two fifths of the Medicare payments for direct and indirect medical education or approximately \$2.7 billion in 1997. This represents an average of 22.5 million dollars per AHC hospital. In addition, AHC hospitals received payments for disproportionate share and, assuming they have a more severe case-mix, higher DRG payments. It should be noted that some of the indirect medical education payments are for unmeasured severity of illness.

According to the Medicare Payment Advisory Commission (formally ProPAC), the PPS operating margin that the average AHC earned from the Medicare program in 1995 was 21.0 percent.¹⁵ In contrast, the average non teaching hospital had a 6.4 percent PPS operating margin from the Medicare program. This suggests that the Medicare program may be overpaying AHCs, at least as measured by PPS operating margins. Other studies have examined specific aspects of the Medicare payment system for direct and indirect medical education and have reached similar conclusions. For many years, ProPAC has found that the indirect medical education adjustment factor used by Medicare over estimates the actual cost of indirect medical education.

As part of the 1997 Balanced Budget Act, Congress revised the payment formula for indirect medical education.^{16,17} Between 1998 and 2002, indirect medical education payments will be reduced by \$5.6 billion. However, another change in the Balanced Budget Act mitigated the impact of these

reductions on AHCs. The AHCs were appropriately concerned that as more Medicare beneficiaries enrolled in managed care, payments for direct and indirect medical education which are based on fee-for-service payments would decline. Congress decided to "carve out" direct and indirect medical education payments from the formula used to pay managed care plans, thereby reallocating \$4.0 billion over this same time period. However, teaching hospitals only receive this \$4.0 billion to the extent they provide actual services to managed care enrollees. The Balanced Budget Act provides payment incentives totaling an estimated \$0.2 billion over the next 5 years for hospitals that reduce residency positions during this time period. HCFA's own internal analysis of the impact of the reductions finds that major teaching hospitals will experience only slightly greater reductions than all hospitals in the first year of implementation from all the provisions in the Balanced Budget Act (-1.6 percent versus -0.9 percent).¹⁷ Five year projections by Medicare Payment Advisory Commission (MEDPAC) show major teaching hospital PPS margins increasing to 24.3 percent in 1997 and staying at that level in 2002 after passage of the Balanced Budget Act.¹⁶

Funding from the Medicaid Program

In 1994, AHC hospitals received 22 percent of their revenues from Medicaid.⁷ During the 1980s and early 1990s most Medicaid programs employed an approach similar to the Medicare program when they designed systems to pay teaching hospitals, explicitly paying for direct and indirect medical education.¹⁸ The Boren Amendment required that Medicaid payments cover the costs of "economically and efficiently operated facilities."¹⁹ To the extent that AHCs had higher costs associated with research, education, specialty services, etc, some courts interpreted the Boren

Amendment to effectively require the states to pay the AHCs for these services.¹⁹ State Medicaid payments for GME were estimated at \$2 billion in 1995 and this does not include another \$3 billion that states spend directly on medical education.²⁰ In addition, many states used a variety of techniques to obtain more federal money for the Medicaid program through a variety of disproportionate share strategies. To the extent that AHCs have more disproportionate share patients, they frequently benefited from these additional Medicaid payments also. An analysis of Medicaid disproportionate share payments suggest that while most of the payments were actually returned to the state by the hospital, the hospitals benefited indirectly because the state had more money to spend on the Medicaid program.²¹

During the early 1990s, however, Medicaid programs began enrolling more beneficiaries in managed care. This reduced the payments for direct and indirect medical education from the Medicaid program and forced the AHCs to negotiate directly with managed care plans for higher payments. A case study of TennCare, for example, documented that one of the primary threats to AHCs in Tennessee was that managed care plans were less likely to admit Medicaid patients to AHCs, thereby reducing revenues to teaching hospitals.²² TennCare initially eliminated all state direct graduate medical education payments to teaching hospitals. Other studies reached similar conclusions about the impact of Medicaid managed care on teaching hospital revenues when they examined other states.^{23,24} In addition, the 1997 Balanced Budget Act repealed the Boren Amendment. The impact of the repeal of the Boren Amendment on AHCs is unknown.

Funding From Private Insurers

In 1994, AHC hospitals received 31 percent of their revenues from private insurers.⁷ Prior to 1990, most private insurers used either cost or charge based reimbursement to pay hospitals. This suggests that private insurers were paying all of the higher costs of the AHCs and the widespread concern over cost shifting suggests that they may have even paid more than actual costs.^{1,2,6} AHC hospitals are 80 percent more expensive per discharge than non teaching, community, urban hospitals with more than 100 beds.^{6,7} However, when casemix, input price differences and other factors are taken into account the difference is reduced. Expenditures per discharge are estimated to be 25 percent greater in AHC hospitals than comparable institutions because of their education and research missions as well as their investment in patient care innovation.^{6,7,12,13,14,27}

With the advent of managed care and increasing levels of price competition, the concern is that some or all private insurers will be unwilling to pay for these services.^{1,2,3} However, we could not identify any comprehensive data on how much the private sector was willing to pay AHCs in the past, is currently paying AHCs, or will pay in the future. A recent surveys of managed care plans and private insurers have placed the increment that managed care plans are willing to pay at 5-10 percent with the premium being only 3-5 percent in the most competitive markets.²⁵ Another study using data on large employer plans places the premium at 12%.²⁶ All of these estimates are below the 25 percent cost differential suggesting that there may be a relative shortfall from the private sector. One concern expressed repeatedly by the private sector is whether the AHCs are as efficient as other hospitals in delivering care.⁵ However, in spite of this anticipated shortfall MedPAC's recent analysis shows the

payment to cost ratio to private major teaching hospitals was 1.17¹⁵ suggesting that the private sector is still paying above costs to these hospitals.²⁸ It should be noted, however, that the payment to cost ratio for private teaching hospitals is the lowest of all categories of hospitals that are listed were analyzed.

Recent Financial Performance of AHCs

ProPAC (now MedPAC) has monitored the total margins of hospitals since it was established in 1984. Recent hospital margin data published by MedPAC show that total margins were 4.5 percent for AHCs and 5.8 percent for all hospitals (Table 1). The total margins for AHCs in 1995 were the highest in ten years. The percentage of AHCs with negative margins also declined from 35 percent in 1989 to 19 percent in 1995. MedPAC also calculates PPS operating margins. The PPS Medicare margin for AHCs was 21.4 percent, also the highest in a decade.^{15,27} This compares to 10.5 percent for all hospitals.

The MedPAC data also allows for comparisons by type of teaching hospital. Of the categories reported, public AHCs had the lowest total margins in 1995, 3.2 percent. In 1995, AHCs located in markets with high managed care penetration had lower total margins than the overall average for all AHCs, 3.6 percent compared with 4.5 percent. However, other studies examining the relationship between margins and managed care penetration reach contrary conclusions. Gaskin and Reuter found AHC margins increasing in areas of high managed care penetration.²⁷ Cleverly found an inverse relationship between managed care penetration and hospital margins in a cross sectional analysis.²⁸

Another way to examine the data is to focus on the hospitals with an operating loss (Table 1). In 1995, 19 percent of all AHCs had negative total margins, compared to 21 percent for all hospitals. AHCs in markets with high managed care penetrations (above 35 percent) however, were more likely to have negative total margins, 24 percent compared with 11 percent of AHCs in low penetration markets (below 20%). Public AHCs were more likely to have negative total margins than private AHCs, 21 percent compared with 16 percent. We also examined the quartile of hospitals with the lowest total and PPS operating margins and were unable to find any category of an AHC hospital that was heavily represented in that group.

Operating margins are only one measure of financial viability. Additional financial ratios for 1993-1997 are presented in table 2.²⁸ On most indicators the financial position of AHCs improved in the period from 1993 to 1997 and are generally comparable to all hospitals. Compared to non teaching hospitals in 1997, AHCs had more cash-on-hand, lower return on equity, more long term debt to equity, lower asset turnover ratios, and higher net assets per bed. The one financial indicator which suggests potential trouble for AHCs are net assets per bed. Net assets per bed in 1997 were \$252,000 in AHC hospitals compared to \$56,000 in non-teaching hospitals. Between 1993 and 1997 days cash-on-hand increased more rapidly in academic health centers. On the other indicators the trends between academic health centers and non teaching hospitals were similar.

Access to Capital

Access to capital is necessary for AHCs. In spite of their higher capital investments, AHCs

still appear to have good access to capital. A recent review by Standard and Poors found that of most AHCs were rated A or AA and concluded that downgrades were unlikely in the near term.²⁹ Overall AHCs have better access to capital than the average community hospital. The analysis found that how individual AHC hospitals are graded depends on a multitude of factors that are specific to the institution, their role in their community and the overall marketplace.

Medical Schools

The financial performance of medical schools also improved in recent years.^{30,31,32} The 1996 Report of the AAMC Task Force on Medical School Financing, for example, found that federal research and faculty practice plan revenues have increased in both absolute and constant dollars from 1990 to 1995 and the number of clinical and science faculty had also increased.³³ A longer run perspective shows similar trends.³⁰ Between 1988 and 1997 the revenue growth in medical schools averaged 10.3 percent, a rate considerably above inflation during this time period. Practice plan revenues increased at 15.3 percent during this same period. In constant dollars the growth rates in the long term (1988-1997) and short term (1996-1997) for total revenues are similar. The rate of increase is down in recent periods from practice plan revenues but the effect is partially offset by greater increases in endowment income.

In spite of these generally positive numbers, there are still concerns about the financial stability of medical schools. Revenue growth per FTE faculty was slow in the 1990s and actually declined between 1994 and 1995.³² Practice plan operating margins declined in the 1990s although they were

still at 12% in 1995.³⁴ They were slightly lower (9%) in areas with high managed care penetration. Margins from faculty practice plans have traditionally been used to cross subsidize other components of the medical school such as the basic science faculty, unsponsored research and education of medical students. This cross subsidization may be eroding as margins decline.³⁷

Although research dollars are increasing in both real and constant dollar terms, competition for grants has become more intense and NIH has recently reduced both direct and indirect cost recovery in a variety of ways. A cap of 26 percent on administrative costs for each grant awarded since 1993 has been imposed. NIH has also clarified which costs were unallowable, clarified definitions and limited charges in specific areas, and required that reimbursement of past facilities expenditures be reinvested in new facilities within five years. In addition, NIH has required more institutional cost-sharing through limitations on investigator salaries and to graduate student stipends that can be made from NIH grants.³

Recent legislative and regulatory changes may have also affected faculty practice plan revenues primarily by reducing payments to specialists. For example, Medicare's change in payment policy to a single conversion factor for physician payment costs may reduce faculty practice plan income from Medicare. The single conversion factor lowers payments to specialists and raises payments to primary care physicians. Since medical school faculties are more heavily populated with specialists, these Medicare changes may disproportionately affect medical schools especially if other payers follow Medicare's lead. In addition, teaching hospitals are concerned with the PATH audits conducted by the Office of Inspector General which threaten to recoup past Medicare reimbursements from faculty

practice plans for alleged double billing. The PATH audits attempt to enforce rules which require an attending physician to be physically present for the key part of the encounter when a service is delivered before the attending physician can bill Medicare when supervising a resident. The medical schools claim the rules were ambiguous and inconsistently enforced in the past. Several hundred million dollars are in dispute.

Data Needs

Numerous data problems were encountered by the Secretary's Task Force on the Future of Academic Health Centers trying to develop public policies for AHCs. There is no consensus on the most valid indicators to monitor the performance of AHCs. There is no single source of data on AHCs and as a result it is frequently difficult to make valid comparisons when different sources use different definitions of AHCs. The Secretary's Task Force recommended addressing these data issues by developing a tracking system for AHCs and affiliated hospitals in conjunction with the provider community. Such a data system would identify the critical financial measures (margins, balance-sheet ratios, cash-flow analysis, bond-ratings, investment in technology) in conjunction with measures of missions (education, research, uncompensated care) and quality of care. It would develop the equivalent of leading economic indicators for AHCs. Meetings with industry representatives have begun.

Unraveling the Paradox

Available data suggests that hospitals affiliated with AHCs are 20-30 percent more expensive than other hospitals because of the costs associated with research, education, innovation in patient care

and other services. Many AHCs have taken actions recently to reduce their costs.^{1,2,3,34,35} This will improve their operating margins however, how long they can continue finding greater efficiencies is unknown. In addition, there is a growing concern that some may alter their social missions in order to maintain their profitability.³⁵

It appears that more than half of the cost differential is being obtained from the federal government, primarily the Medicare program. In addition to Medicare payments for direct and indirect medical education, the Veteran's Administration supports approximately 8900 (approximately 10 percent) of the residents and has a biomedical, rehabilitation and health services research budget that exceeds \$1 billion. The stipends for trainees in VA hospitals were .4 billion in 1997. The Bureau of Health Professions provided \$0.3 billion through titles VII and VIII of the Public Health Service Act for health professions training. States support undergraduate and graduate and some local and state governments underwrite the deficits of public teaching hospitals. One possible explanation for the financial paradox is that most of the differential is already being provided by public sources.

Changes in the distribution of funding may be responsible for many of the concerns raised by AHCs. In the past, AHCs received funds from multiple sources. In 1980, for example, medical schools received approximately one quarter of their revenues from federal research; one quarter from state and local appropriations; and one quarter from medical services. By 1995, the distribution had changed dramatically with medical services responsible for almost half of the revenues. This growing concentration of funding may be partially responsible for their increasing level of anxiety.

Recently, much of the surplus or cross subsidy for AHC hospitals appears to come from one source -- the Medicare program. Considerable uncertainty exists about the reliability of this funding source in the future. Higher payments from multiple private sector insurers were a more reliable source of revenues. However, with the growth of managed care and the advent of price competition, the situation has changed dramatically. AHCs are potentially having to accept lower payments from the private sector in order to compete for managed care contracts, reducing the subsidies they receive from the private sector for their missions.

Anxiety levels are likely to remain high until a stable funding source is found which is outside of the annual government appropriations process. For example, the national Bipartisan Commission on the Future of Medicare is considering severing the tie between graduate medical education and the Medicare program. The Commonwealth Task Force on Academic Medical Centers has proposed that government funding be established to support the social mission of AHCs.⁵ However, given the vicissitude of the annual appropriations process, this is also not likely to be a guaranteed source of funding.

Discussions of increased government funding are also frequently linked to discussions of public accountability. Currently most funds for graduate medical education flow automatically to AHCs as patient care sources are provided. The hospitals and medical schools are free to spend those funds as they wish. Proposals to channel funding to AHCs for specific missions (e.g., unfunded research, training of certain types of specialists, innovation, multidisciplinary training, indigent care, etc.) reduce the financial discretion of medical school deans, hospital managers and department heads.

As long as the public sector continues to pay a large proportion of the incremental costs of AHCs through the Medicare program, Veterans Administration and other public sources and the private sector is willing to pay some increment to AHCs, the long run financial viability of AHCs looks secure. Funding in both the Medicare program and Veterans Administration look stable at least through 2002, although there are no guarantees. In the long run, however, society may need to define what services it wants AHCs to provide, how it will hold AHCs accountable for the delivery of those services, and develop a long run stable financing structure to support these services. At the same time AHCs may need to change and become more accountable to the public.^{1,2,3,34,35} Although AHCs are already responding to a changed environment, they will need to further reduce costs; become more responsive to patients, payors and managed care plans; and perhaps alter their mix of training programs.

Table 1
Hospital Margins

Total Hospital Margins				
	<u>1989</u>	<u>1991</u>	<u>1993</u>	<u>1995</u>
All Hospitals	3.6	4.4	4.5	5.8
AHCs	1.3	4.3	3.4	4.4
AHCs in MSAs with >35% Managed Care Penetration	1.0	5.0	4.3	3.6
Public AHCs	0.1	4.8	3.9	3.2
Private AHCs	2.0	4.0	3.2	5.4
Large Urban AHCs	1.1	3.7	3.3	4.0
Percent of Hospitals with Negative Total Margins				
All Hospitals	32	26	24	21
AHCs	35	21	22	19
AHCs in MSAs with >35% Managed Care Penetration MSAs	38	22	26	24
Public AHCs	47	23	17	21
Private AHCs	25	20	25	16
Large Urban AHCs	40	22	23	22

Table 2
Financial Performance Indicators

Indicator	AHC Hospitals			Non-AHC Hospitals		
	1993	1996*	1997**	1993	1996*	1997**
Days Cash on Hand	86.2	88.6	95.6	37.1	44.7	39.9
Return on Equity	5.6	7.0	7.2	7.8	9.2	9.3
Percent Equity Financing	52.1	54.0	59.9	51.8	55.8	59.3
Long Term Debt to Equity Ratio	50.4	47.3	39.8	34.7	29.7	23.7
Asset Turnover Ratio	.94	.88	.86	1.08	1.07	1.08
Net Assets Per Bed	201,000	223,000	252,000	55,000	59,000	56,000

Source: Center for Health Care Industry Performance Studies analysis performed for Secretary's Task Force on Academic Medical Centers, July 29, 1997 and reanalysis September 24, 1998.

Data available to the Secretary's Task Force were only through 1995.

** Data available for 1997 only on a subset of hospitals.

Endnotes

1. J. Kassirer, "Academic Medical Centers Under Siege," *New England Journal of Medicine* 331, no. 20 (1994): 1370-1.
2. D. Blake, "Whither Academic Values During the Transition from Academic Medical Centers to Integrated Health Delivery Systems?," *Academic Medicine* 71 (1996): 818-19.
3. J. Iglehart, "Rapid Changes for Academic Health Centers," *New England Journal of Medicine* 331, no. 20 (1994): 1391-5.
4. There are a small number of studies that examine recent changes in the mission of AHCs. Dobson and Mechanic did not find a significant impact of managed care on clinical research. However, Moy, et. al. found a negative correlation between NIH grants and managed care penetration and Blumenthal et.al present evidence that support for junior faculty declines and tensions among research faculty increases in high managed care markets. With regard to uncompensated care, Zwanziger et.al found that hospital uncompensated care caseloads stabilized between 1990 and 1995 although they present evidence that hospitals in areas with high managed competition or with high Medicaid caseloads are under increasing financial pressure. Cunningham and Hu present data which shows that although the total percentage of uncompensated care is increasing, uncompensated care is becoming increasingly concentrated in public hospitals and

Endnotes

1. J. Kassirer, "Academic Medical Centers Under Siege," *New England Journal of Medicine* 331, no. 20 (1994): 1370-1.
2. D. Blake, "Whither Academic Values During the Transition from Academic Medical Centers to Integrated Health Delivery Systems?," *Academic Medicine* 71 (1996): 818-19.
3. J. Iglehart, "Rapid Changes for Academic Health Centers," *New England Journal of Medicine* 331, no. 20 (1994): 1391-5.
4. There are a small number of studies that examine recent changes in the mission of AHCs. Dobson and Mechanic did not find a significant impact of managed care on clinical research. However, Moy, et. al. found a negative correlation between NIH grants and managed care penetration and Blumenthal et.al present evidence that support for junior faculty declines and tensions among research faculty increases in high managed care markets. With regard to uncompensated care, Zwanziger et.al found that hospital uncompensated care caseloads stabilized between 1990 and 1995 although they present evidence that hospitals in areas with high managed competition or with high Medicaid caseloads are under increasing financial pressure. Cunningham and Hu present data which shows that although the total percentage of uncompensated care is increasing, uncompensated care is becoming increasingly concentrated in public hospitals and hospitals already providing high levels of uncompensated care. Based on AHA data, Blumenthal,

Campbell, and Wiseman document that the uncompensated care caseloads of hospitals affiliated with Academic Health Centers increased from 9.35 to 11.7% of gross patient revenue. Gaskin and Reuter found that hospitals affiliated with AHCs in areas of high managed care competition were less likely to receive patients from managed care plans but that the same hospitals improved their financial margins and increased their uncompensated care loads.

5. The Commonwealth Task Force on Academic Health Centers, *Leveling the Playing Field: Financing the Missions of Academic Health Centers* (Boston: May, 1997).

6. G. Anderson, J. Lave, C. Russe and P. Neuman, *Providing Hospital Services: The Changing Financial Environment* (Baltimore: The Johns Hopkins University Press, 1989).

7. J. Reuter, *The Financing of Academic Health Centers: A Chart Book* (Washington, D.C.: Institute for Health Care Research and Policy, 1997).

8. Report by The Task Force For The Initiative On the Future of Academic Health Centers: Review of Department Policies and Recommendations, October 7, 1997.

9. Whenever possible, we use the term hospitals affiliated with AHCs to distinguish the approximately 118 teaching hospitals listed by AAMC as either integrated with or associated with medical schools. MedPAC and HCFA define major teaching hospitals as teaching hospitals with a ratio of residents to hospital beds of 0.25 or more. There are approximately 250 major teaching

hospitals by this definition. There are approximately 400 members of the Council of Teaching Hospitals (COTH). Some studies of teaching hospitals use COTH membership as the universe for analysis. Finally, there are approximately 1200 hospitals with at least one resident, comprising the broadest possible universe of teaching hospitals.

11. J. Iglehart, "Health Care Reform and Graduate Medical Education," *New England Journal of Medicine* 330, no. 16 (1994): 1167-71.

12. J. Pettingill and J. Vertrees, "Reliability and Validity in Hospital Case-Mix Measurement," *Health Care Financing Review* 4 (1982).

13. K. Thorpe, "The Use of Regression Analysis to Determine Hospital Payment: The Case of Medicare's Indirect Teaching Adjustment," *Inquiry* 25 (1988).

14. G. Anderson and J. Lave, "Financing Graduate Medical Education: Using Multiple Regression to Set Payment Rates," *Inquiry* 23 (1986): 191-99.

15. Medicare Payment Advisory Commission, *Health Care Spending and the Medicare Program: A Data Book* (Washington, D.C.: MedPAC, July 1998).

16. S. Gutterman, "The Balanced Budget Act of 1997: Will Hospitals Take a Hit on their PPS Margins?", *Health Affairs* 17(1):159-66, 1998 Jan-Feb

17. Federal Register, August 29, 1997: 4126-7.
18. D. Plumb and T. Henderson, *Medicaid Funding of Graduate Medical Education: A Survey of the States* (Washington, D.C.: George Washington University Press, 1995).
19. G. Anderson and M. Hall, "The Adequacy of Hospital Reimbursement Under Medicaid's Boren Amendment," *The Journal of Legal Medicine* 13 (1992): 205-236.
20. R. Cunningham, "States Exploring New Roles as Catalysts in GME Restructuring," *Medicine and Health* 51, no. 36 (1997).
21. Leighton Ku and Theresa Coughlon, "Medicaid Disproportionate Share and Other Special Financing Programs", HCEA Review, Spring 1995, Vol. 16, No 3, pp 27-40.
22. D. Blumenthal and G. Meyer, "Academic Health Centers in a Changing Health Care Environment: Results of Seven Case Studies," *Health Affairs* 15, no. 2 (1996): 201-15.
23. J. Mann et al., "A Profile of Uncompensated Hospital Care," *Health Affairs* 16, no. 4 (1997): 223-32.
24. P. Cunningham, "A Changing Picture of Uncompensated Care," *Health Affairs* 16, no. 4

1997).

32. Association of American Medical Colleges, *AAMC Data Book: Statistical Information Related to Medical Education* (Washington, D.C.: Association of American Medical Colleges, 1995).

33. Association of American Medical Colleges, *The Financing of Medical Schools - A Report of the AAMC Task Force on Medical School Financing* (Washington, D.C.: AAMC, 1996), 18.

34. H. Pardes, "The Future of Medical Schools and Teaching Hospitals in the Era of Managed Care," *Academic Medicine* 72, no. 2 (1997): 97-102.

35. D. Blumenthal, E.G. Campbell, and J.S. Weissman, "The Social Missions of Academic Health Centers," *New England Journal of Medicine* 337, no. 21 (1997): 1550-53.

(1997): 167-75.

25. M. Gold, "Effects of the Growth of Managed Care on Academic Medical Centers and Graduate Medical Education," *Academic Medicine* 71, No. 8 (1996): 828-838.

26. D. Blumenthal and G. Meyer, "Update: Safety-Net Providers," *Health Affairs* 16, no. 4 (1997): 275.

27. J. Reuter and D. Gaskin, "Academic Health Centers in Competitive Markets: How AHCs are Coping with Reduced Revenue and Increased Competition for Managed Care Patients," *Health Affairs* 16, no. 4 (1997): 242-52.

28. W. Cleverley, *The Almanac of Hospital Financial and Operating Indicators* (Columbus, Ohio: The Center for Healthcare Industry Performance Studies, 1996).

29. David Pekne and Jennifer Neel, "Academic Health Centers Work to Balance High-Level Care With Attention to Cost," *Standard and Poor's Viewpoint on Health Care* (September 18, 1996).

30. R. Jones, J. Ganem, D. Williams and J. Krakower, "Review of US Medical School Finances, 1996-1997," *JAMA* 280, no. 9 (1998): 813-818.

31. Physician Payment Review Commission *Annual Report to Congress 1997* (Washington, D.C.:



N • A • C • H • • • • •

THE NEED FOR COMMENSURATE FEDERAL GME FINANCING FOR FREESTANDING CHILDREN'S HOSPITALS

September 23, 1998

Children's Teaching Hospitals at a Glance

Freestanding children's hospitals are hospitals that serve primarily children and do not share a Medicare provider number for purposes of third party payment with another institution. In 1998, there are 55 such institutions nationwide, consisting of 45 acute care children's hospitals and 10 children's long-term specialty hospitals. These hospitals include the leading pediatric medical centers in the country.

Like other teaching hospitals and, in particular, academic medical centers, children's hospitals tend to treat the most severe, costly cases, while supporting high quality research and teaching programs. An increasingly competitive health care market dominated by managed care tends not to recognize these differences. Moreover, unlike adult teaching hospitals, children's hospitals have few Medicare patients, and therefore receive almost no federal graduate medical education (GME) funding for their residency positions. Caught in a financial vise between the pressures of market competition and the demands of teaching, research and high quality care programs, some dimensions of the children's hospitals' mission will begin to suffer.

Children's hospitals were established to provide centers for medical care that put the needs of children foremost. From the beginning, they have provided family-centered care, delivering the full range of services needed to care for the child and to support the family throughout the child's course of treatment. They have provided health professionals experienced in the care of children, who recognize that a child's illnesses, treatments, and health care needs are often significantly different than adults. And, they have provided regional centers for highly specialized pediatric care. Since few children require such care, these regional centers are often essential to assuring its availability.

The children's hospitals have assumed three major missions – patient care, research and teaching -- all devoted to children's unique health care needs. They are committed to providing quality health care for all children, regardless of their families' ability to pay. Today, on average, almost 50 percent of the patient care that freestanding children's hospitals provide is for low income children, either those covered by Medicaid or those who are uninsured. More than 75 percent of the inpatient care provided by children's hospitals is devoted to children with one or more chronic conditions.

The acute care children's hospitals offer the complete range of patient care services for children, from inpatient to ambulatory care. They are regional and national referral centers for very sick children, often serving as the only source for many critical pediatric services. They also serve as the major source of pediatric care in many of their service areas and are often the largest providers of primary care to youngsters in their communities, with clinics serving area neighborhoods.

It is their commitment to children and the close tie between their patient care, research and teaching that truly set these hospitals apart. As major teaching hospitals, they train a substantial portion of our

country's pediatric workforce – more than 25 percent of all pediatricians and over half of many pediatric subspecialists, as well as a substantial number of required pediatric rotations for many other residency programs. As academic medical centers devoted to children, they have developed “bench to bedside” research environments that have led to scientific discoveries, which, in turn, have helped to set the standard for pediatric care and research around the world. The freestanding children's hospitals and their affiliated pediatric departments account for one-quarter of all National Institutes of Health (NIH)-sponsored pediatric research.

Current Challenges

The rapid expansion of a competitive marketplace driven primarily by price is posing significant challenges for all health care providers. Children's hospitals face many of the same problems of other “safety net” providers and teaching hospitals. They care for a significant portion of the low-income, vulnerable population that often requires special consideration. They maintain essential community and critical care services, whose costs are never fully covered. And, they provide a higher level of complex care to more severely ill patients than other institutions. (See attached “Indicators...”)

*

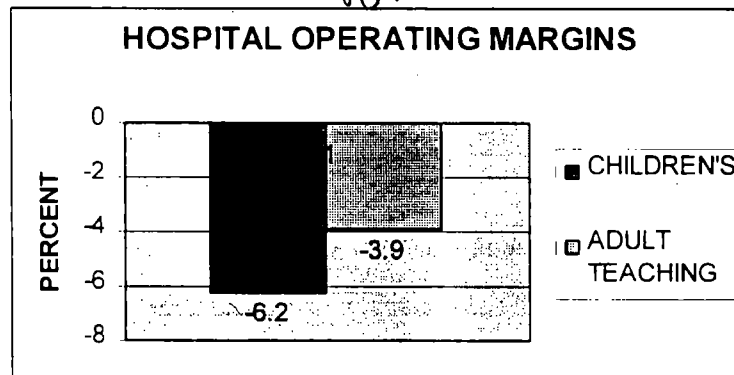
The higher costs resulting from the greater staffing and equipment needs of pediatric care make the last point an even greater problem for the freestanding children's hospitals. For example, a child under age two can require on average 40 percent more nursing care per hour of an inpatient stay in a hospital than an adult inpatient will require. These differences in cost are increasingly unrecognized by a more competitive medical marketplace.

For teaching hospitals, no challenge is greater than their growing inability to recover the costs of GME. Medicare has become the mainstay of GME funding as Medicaid's moves to managed care have resulted in fewer states paying even the direct costs of GME. Other, private payers are increasingly unwilling to support GME costs at all. For the freestanding children's hospitals, with only a very few Medicare patients – children with end stage renal disease -- the GME financing issue is critical.

Even as children's hospitals maintain, and often increase, pediatric market share, their patient care revenues are falling short of covering their patient care costs. A significant percentage of this loss, half or more in many cases, is attributable to unreimbursed GME costs. This is reflected in children's teaching hospitals' operating margins, which are substantially lower than other teaching hospitals.

According to 1995 Hospital Cost Report Information System (HCRIS) data, children's hospitals' operating margins were negative 6.2 percent, on average, compared to negative 3.9 percent for other teaching hospitals.] GME losses per hospital run in the millions of dollars per year and cannot be sustained.

general diff positive.



pt care income

cost of pt care

total income

total costs.

Data reported to the National Association of Children's Hospitals and Related Institutions (NACHRI) suggest that freestanding children's teaching hospitals' net patient revenues in FY1996 accounted for about 94% of total operating expenses. (The freestanding children's hospitals' total margins still remain

from the
hennin
how are
operating
margins
defined? def used
by hennin group.
(total margins?)

sound in most cases, because they and their trustees have devoted themselves to building resources to assure the hospitals' future and missions. However, operating margins that continue at this negative rate eventually erode endowment income, as increasing proportions of charitable contributions and endowment income must be diverted simply to cover operating margin deficits.

Endowment income and charitable contributions vary widely among institutions, but their intended purpose is typically the same:

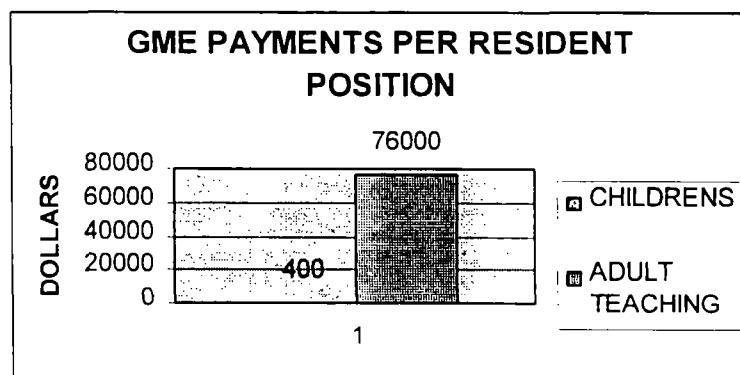
- They support both primary and specialty care services for children who have inadequate or no health care insurance, as well as related services that often are needed to ensure that children of low income families have access to the services they need, such as transportation and social services.
- They provide the investments in start-up and uncovered indirect costs, which research programs must have, and they support unsponsored research, which funds new investigations, serving as a source of funds for creative research topics.
- They support essential facilities maintenance and improvements, which often are an important part of the hospital's overall efforts to remain competitive with other facilities.
- They support community services, including services for children for which reimbursement often is inadequate or non-existent, such as child abuse treatment, child life, and poison control centers.
- They make possible many of the hospitals' efforts to promote the health and well-being of all of the children of the community, not just their patients, such as public education programs for car seat and seat belt safety, motorcycle and bike helmet safety, immunizations, hot water and pool safety, firearms safety, children abuse prevention, and more.

Often, these resources are significantly restricted for specific purposes. The demands on this income have never been greater, particularly at a time when the hospital industry overall is experiencing a significant decline in philanthropic support in recent years, according to the Association for Healthcare Philanthropy. And, often, the hospitals possess neither the flexibility nor the capacity to create or sustain donor or operating income endowments to support GME.

Finding a Solution

The National Association of Children's Hospitals (N.A.C.H.) has long supported a broad-based financing system for graduate medical education, an approach that could include our nation's freestanding children's hospitals. If such a broad-based system is not imminent, however, the children's hospitals must seek an interim solution.

endowment levels



The current system of financing GME has created a serious inequity for these institutions. Competitors either have no academic missions or they receive federal support for GME through Medicare in combined direct and indirect medical education payments. Based on the most recent HCRIS data, teaching hospitals overall receive on average over \$76,000 per resident a year from Medicare, while the freestanding children's hospitals receive less than \$400, on average. However unintended it may be, this huge difference in federal support creates a dramatic competitive disadvantage for these children's hospitals.

Providing a level playing field for GME for the freestanding children's hospitals would enable them to remain competitive in an increasingly tight market, allow them to offer a better value for the consumer, and prevent fragmentation of pediatric services. For some of the freestanding children's hospitals, this is an issue of immediate, serious financial concern. For others, it is an issue of diverting other critical resources to GME. For many, decisions to reduce residents are being made.

The field of pediatrics cannot afford the risk of freestanding children's hospitals being forced -- by a federal GME funding policy tied largely to patients they do not serve -- to reduce or abandon their academic missions. Not only do they train a significant portion of the nation's pediatric health professionals, most of whom are in primary care, they provide this training in an environment where residents can experience the entire range of pediatric care. It takes a substantial pediatric patient population to provide this range. In addition, the hospitals' academic programs provide the underpinning of their research programs and contributions to the advancement of pediatric medicine. Eliminating their teaching programs would fundamentally alter the missions of these institutions.

Because of the significance of this problem, not just for the affected children's hospitals but for the entire field of pediatric medicine and the future pediatric workforce, the American Academy of Pediatrics, Association of American Medical Colleges, Association of Medical School Pediatric Department Chairs, Conference of Boston Teaching Hospitals, Utah Medical Education Council, and National Association of Children's Hospitals strongly support efforts to provide commensurate federal direct and indirect medical education support for freestanding children's teaching hospitals, including interim support until comprehensive GME financing reform is achieved.

Request to The Bipartisan Commission and MedPAC

As the National Bipartisan Commission on the Future of Medicare and the Medicare Payment Advisory Commission consider their recommendations to Congress on graduate medical education, N.A.C.H. asks that the freestanding children's hospitals be included in the deliberations. Currently, proposed bipartisan legislation in the House and Senate, the "Children's Hospitals Education and Research Act," H.R.3855 and S.2049, would provide federal GME funding to the children's hospitals on an interim basis -- two to four years -- prior to the achievement of any broad-based reform. (See attachment "Support for...")

N.A.C.H. would appreciate the opportunity to assist the Commission in assessing both interim and long-term approaches to equitable GME financing for these institutions.

use survey instrument like
 AHA survey; own analyses
 diff than HCIS - free standing acute care
 Indicators of Financial Status
 of Children's Teaching Hospitals
 with Their Own Medicare Provider Numbers

diff than
 rehab -
 Lewis data includes
 both.

The following data on the performance of freestanding, acute care children's teaching hospitals for FY 1996 were reported to the National Association of Children's Hospitals and Related Institutions (NACHRI). The reporting hospitals represent the largest of the nation's children's teaching hospitals with their own Medicare provider numbers.

Safety Net Service

Because they are devoted to caring for all children, regardless of economic or medical condition, children's hospitals are major providers of care for children who rely on Medicaid. Over the three most recent fiscal years for which data are available, children's teaching hospitals on average devoted nearly half of their care to children of low income families - 42% Medicaid and 6% bad debt/charity. The balance included 1% Medicare, 2% other government, and 49% commercial/direct employer coverage.

Gross revenues
 total gross revenues
 Medicaid, Bad Debt, and Charity:
 48% of Gross Revenues

Because of their volume of service to children of low-income families, children's hospitals are often the recipients of significant Medicaid disproportionate share (DSH) payments. However, even with DSH payments, Medicaid reimbursement still falls far short of the cost of caring for Medicaid patients. Medicaid reimbursement, including DSH payments, averaged only 81% of expenses. Without DSH payments, Medicaid reimbursement averaged only 74% of expenses.

Medicaid and DSH Reimbursement: 81% of Costs
Medicaid without DSH Reimbursement: 74%

Financial Performance

While children's teaching hospitals, on average, operate in the black, they do so only marginally. Total Net patient revenues fell short of their total operating expenses -- about 94% of total operating expenses.

Net Patient Revenue/Total Operating Expenses: 94%

Case Mix Intensity

Compared to other hospitals, children's teaching hospitals have significantly greater case mix intensity. Children's teaching hospitals' case mix index averaged 1.47, compared to 1.29 for all teaching hospitals, and 0.74 for community hospitals.

Case Mix Index for Children's Teaching Hospitals: 1.47
Case Mix Index for All Teaching Hospitals: 1.29
Case Mix Index for Community Hospitals: 0.74

more sp.
 than
 HCFA

pediatric
 care

take sum of relative wts for all cases in
 total discharges

see
 reported?

pts days?
 services?
 #s?

all cases
 using
 DRG
 base amt

hosp

HCFA	Medicare	Medicaid	Help	Feedback	Search	FAQs
-------------	-----------------	-----------------	-------------	-----------------	---------------	-------------

National Summary of Medicaid Managed Care Programs and Enrollment

June 30, 1997
Managed Care Trends

	Total Medicaid Population	FFS Population	Managed Care Population	% Managed Care Enrollment
1991	28,280,000	25,583,603	2,696,397	9.53%
1992	30,926,390	27,291,874	3,634,516	11.75%
1993	33,430,051	28,621,100	4,808,951	14.39%
1994	33,634,000	25,839,750	7,794,250	23.17%
1995	33,373,000*	23,573,000*	9,800,000*	29.37%*
1996	33,241,147	19,911,028	13,330,119	40.10%
1997	32,092,380	16,746,878	15,345,502	47.82%

* Indicates approximate numbers. Total Medicaid population was provided by the Office of the Actuary which used 2082 data to calculate average Medicaid enrollees over 1995. The managed care population differs from the 11,619,929 reported in the 1995 report as the number represented enrollment of some beneficiaries in more than one plan.

The 1996 and 1997 Total Medicaid Population was collected by States at the same time the managed care enrollment numbers were collected instead of using 2082 data as had been done in previous years.



[Return to Medicaid Managed Care Page](#)

Last Updated February 27, 1998

HCFA	Medicare	Medicaid	Help	Feedback	Search	FAQs
-------------	-----------------	-----------------	-------------	-----------------	---------------	-------------

Sheneta Allen
672

TYPE OF SPENDING

3 MEDICARE X

- MEDICATION
- NEW MANDATORY ~~ENTITLEMENT~~
OR GRANT PROGRAM + TRUST
- NEW DISCRETIONARY PROGRAM

Amount ~~PER~~ FORMULA

- Current MCR
 - GMB
 - LMB
- PER RESID

AMOUNT
100% 288

Made your AS -
residents;

Note: I also noticed
a 1995 CSO
Study on AME you
MIGHT WANT
TO
CHECK
OUT.

OPTIONS FOR PROVIDING GRADUATE MEDICAL EDUCATION FUNDS TO FREESTANDING CHILDREN'S HOSPITALS

- **Modify the Kerrey proposal to provide reimbursement for those GME costs associated with providing care to publicly insured patients.** Under the Kerrey proposal, general appropriation funds would be distributed to children's hospitals based upon a formula resembling the Medicare formula currently used to determine GME reimbursement. The Kerrey proposal provides the children's hospitals with DME reimbursement based on a flat per resident amount, without consideration for the percentage of their expenditures associated with providing care to Medicare or Medicaid patients. This option would modify the DME formula in the Kerrey legislation to ensure that the children's hospitals only received reimbursement for the portion of their DME expenses associated with providing care to Medicare and Medicaid patients. The IME formula could be modified in a similar fashion. This proposal would also ~~permit the~~ Secretary ~~to~~ prospectively limit the funds disbursed to the amount appropriated, ~~rather than~~ ^{rather than} ~~recover overpayments retrospectively~~ ^{recover overpayments retrospectively}.

- **Eliminate IME reimbursement from the Kerrey proposal.** The Kerrey proposal requires the Federal government to provide approximately \$76,000 per resident for DME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs. The proposal could be modified to exclude reimbursement for IME and reimburse for only DME costs. This would provide the children's hospitals with the commensurate funding they are seeking. The proposal would include a provision that would allow the Secretary to prospectively limit the funds disbursed to the amount appropriated. ~~However~~ ^{without modifying the DME formula in the}

- **Require Medicare to disburse GME funds based on a flat, per resident amount.** This Kerrey proposal would provide children's hospitals with graduate medical education funding according to a flat, per resident amount adjusted for geographic variation in health care costs that would be determined by HCFA and disbursed through the current GME reimbursement system used by HCFA. The amount of funding an institution received would be dependant solely on the number of residents it had enrolled. Funds would be provided through a general appropriation, and there would be a cap on the amount of funds that could be disbursed. ~~to discuss~~ ^{This is a simpler formula than the Kerrey proposal and essentially has the same distributional effects. However, the Children's Hospitals may prefer the formula to resemble that for other teaching hospitals.}

- **Create a discretionary grant program to provide GME funds.** This proposal would require children's hospitals to submit an application to receive a GME grant. Potential grantees would submit a summary detailing the extent of their financial need, an overview of their curriculum and training, and their previous experience in providing graduate medical education. Based on Federal review of the grant proposal, hospitals could receive different levels of funding.

On one... would essentially double these populations, for children's hospitals get DSH, for other teaching hospitals.

Note:
All our
options except last
should be
funded through
capped
mandatory
grant
program.

creates a
discretionary
grant program
through PHS
rather than
Medicare.
It could use
either the
or the
flat, per resident
distributing
Alternative
could

also, option 2 would (if the
of residents stays roughly
the same) ~~not~~ require any
adjustment, regardless of
prospective or retrospective.

Minor
change
on
Page
3

RESEARCH REPORT

What Does Not Explain the Variation in the Direct Costs of Graduate Medical Education

Gerard F. Anderson, PhD

ABSTRACT

Background. There is considerable variation in the costs of training residents across hospitals. Previous studies have reported training costs that range from \$7,500 to \$200,000 per resident, with means in the \$50,000 to \$60,000 range. This paper examines the factors associated with the variation in the direct costs of residency education across hospitals.

Method. Hospital costs, hospital payment rates, various cost-of-living indices, and hospital characteristics for all hospitals in the United States receiving Medicare funds for residency education in fiscal year 1991 were obtained from various public sources. Bivariate and multivariate analyses were performed to determine whether organizational structure of residency training, specialty mix of residents, quality of training, cost of living in the geographic area, patient mix of the hospital, or other factors could explain some or all of the cost variation.

Results. Only a small proportion of the variation in the costs of training residents or payments for residency education could be explained by the factors analyzed.

Conclusion. Much of the current variation in residency costs and payments is attributable to accounting and not structural or locational factors. Institutions looking for ways to become more efficient could compare costs of training across institutions without sophisticated adjusters. Federal policymakers should consider a national payment rate per resident to replace the current system based on hospital-specific costs. This proposal would redistribute dollars across residency programs. The proposal would affect payments for direct medical education in the Medicare program and could form the basis for payment for residency education by all payers.

Acad. Med. 1996;71:■■■■-■■■■.

Studies have reported considerable variation in the direct costs of training residents in hospital settings. According to Medicare cost reports and hospital surveys, the direct costs to individual hospitals of training residents in the late 1980s ranged from \$7,500 to \$200,000, with means in the \$50,000-\$60,000 range.¹⁻³ These studies also showed that approximately two-thirds of the hospitals had direct costs per resident in the \$20,000-\$80,000 range.

The means and ranges of reported costs varied slightly from study to study because different data sources were used, different samples of hospitals were studied, different years were examined, and different algorithms for truncating high and low values for individual hospitals were employed.

The large variation in the reported costs of training residents raises both institutional and public policy issues. One institutional question concerns the factors associated with the variation in the direct costs of residency education. It is possible that factors such as the organizational structure of residency training, the specialty mix of residents, the quality of the training, the cost of living in the geographic area, and the patient mix at the hospital could explain some or all of the cost variation. A related institutional ques-

tion is what components of residency training are responsible for most of the cost variation. Is most of the variation attributable to differences in the amounts paid to residents or is most of the difference attributable to differences in supervisory-physician costs and the administrative costs of residency training? Answers to these questions could help hospital managers and program directors compare the costs across hospitals and look for areas of potential cost reduction within their own institutions.

The results of this inquiry could have important public policy implications, since the Medicare program currently pays hospitals for residency training on the basis of hospital-specific costs. According to the early-1995 estimates of the Health Care Financing Administration (HCFA) actuaries, ap-

Dr. Anderson is the director of the Center for Hospital Finance and Management, professor in the Department of Health Policy and Management, and professor of medicine at The Johns Hopkins University, Baltimore, Maryland.

Correspondence and requests for reprints should be addressed to Dr. Anderson, Johns Hopkins Health Institutions, Center for Hospital Finance and Management, 624 North Broadway, 3rd Floor, Baltimore, MD 21205.

proximately \$1.8 billion would have been paid to hospitals by the Medicare program in fiscal year (FY) 1995 for direct medical education, and \$2.5 billion will be paid in FY 2000. Currently, hospitals are paid for graduate medical education based upon the costs they reported to Medicare in 1984, with adjustments for inflation in the subsequent years. Because of the wide variation in direct costs across hospitals in 1984, current Medicare payments per resident can be three or four times larger in one hospital than in another hospital. It is unclear, however, whether these payment differentials can be justified based upon objective factors or even whether the current payment differentials are consistent with the differences found in more recent Medicare cost reports. As part of health care reform, President Clinton proposed to pay hospitals a single national rate for residency education, with unspecified adjusters for cost of living.⁴ In addition, the Medicare program has considered changing to a national rate, and several members of Congress have proposed to pay for residency education based upon a national rate. If a national payment rate for residency education is to be adopted, it is important to examine whether there are any factors that should be used to adjust the national payment rate.

METHOD

The most commonly used source for estimating direct costs per resident is the Medicare cost report.^{1,3,5,6} The major advantage of this source is that it is possible to obtain information about the costs of all accredited hospital-based residency programs. In addition, Medicare has promulgated regulations governing what costs can and cannot be included on the cost report, and audits the information that is reported.

Within the Medicare cost report there are several places where the direct costs are reported. For most hospitals,

actual reported costs will vary depending on where in the Medicare cost report the data are obtained. This is because of the way costs are allocated to individual cost centers in different sections of the Medicare cost report. When I report the total cost of residency training, I use information from worksheet B, lines 21 and 22. However, when I am interested only in the cost of the resident stipend (salary and fringe benefits), I use the information from worksheet B, line 21. Both these sources provide data before allocation of overhead costs. This avoids incorporating differences in costs that are unrelated to the costs of residency training, such as cost of operating the physical plant. The number of residents is obtained from worksheet S3, line 8, column 7. Information about the characteristics of the hospital, including geographic location, ownership, percentage of revenues from the Medicare program, disproportionate share status, and bed size, were also obtained from the Medicare cost report. I used data from the Hospital Cost Report Information System (HCRIS) file for FY 1991, which abstracts Medicare cost reports for all U.S. hospitals whose 1991 fiscal years began between September 30, 1990, and October 1, 1991. The HCRIS file was obtained directly from HCFA.

Information from the most recent Medicare cost report is not used to determine Medicare payments for direct medical education. The Medicare program pays hospitals based upon a formula that begins with the hospital's own reported costs in 1984 and updates these "costs" using the Consumer Price Index for All Urban Consumers.⁷ Actual payment rates for individual hospitals were obtained directly from HCFA.

Additional data sources were used to obtain three cost-of-living indices. Cost-of-living differences could explain some of the variation in the costs of training residents. The three indices we examined were (1) the wage index used

by HCFA to adjust payments for hospital services in the Medicare program,⁸ (2) the nearest-neighbor index proposed by the Prospective Payment Assessment Commission (ProPAC) as a replacement for the HCFA wage index,⁹ and (3) the physician geographic-cost index used to adjust payment rates for physicians in the Medicare program.⁸ These indices were obtained directly from HCFA and ProPAC.

For certain analyses it was not possible to obtain the necessary information for all hospitals with residency programs in the United States. For analyses relating to the variation in resident stipends by year of training specialty, I used a data set maintained by the Association of American Medical Colleges (AAMC) from its 1992 Survey of Hospitals' Financial and Operating Data and the Housestaff Salary Survey, 1993. The first is a survey of 219 academic medical centers and major affiliated institutions. The second is a survey of 328 member institutions. I used data for 197 hospitals that completed both surveys. From the two surveys, I obtained the average stipend per year of training for each hospital (S_{yh}), where S = stipend per resident, y = year of training, and h = hospital.

I then calculated an overall average stipend for each year of training for all hospitals by multiplying the average stipend per year of training for each hospital (S_{yh}) by the number of residents by year in each hospital (R_{yh}), summing across all hospitals $\sum (S_{yh}) \times (R_{yh})$, and then dividing by the total number of residents by year ($\sum R_{yh}$). The result was an overall average stipend for each year of training across all hospitals (AS_y). I then multiplied the national average stipend for each year of training (AS_y) by the number of residents in that year (R_{yh}) for each hospital and divided by the total number of residents in that hospital ($\sum R_{yh}$). The final calculation is the average resident stipend in that hospital if the hospital paid the average stipend

Table 3

Variations in Costs per Resident by Number of Residents in Program*

No. of Residents In Program	Total Cost per Resident
1-9	\$53,777
10-19	\$55,797
20-29	\$54,820
30-39	\$60,236
40-49	\$57,792
50-99	\$60,178
100-199	\$64,865
200+	\$54,949

*The table data are from 1,185 U.S. hospitals in fiscal year 1991.

tween cost per resident and any of the indices does not exceed .19. Correlations between the indices and payments per resident were slightly higher, ranging from .16 to .28, with the ProPAC nearest-neighbor index showing the highest correlation.

Another way to demonstrate the extent of the correlation between cost of living and total cost per resident is to examine the variation within a single geographic area where the cost of living should be relatively constant. We ex-

amined the variations in total costs and payments per resident for the 50 hospitals in New York City with residency programs (Figure 1). The hospitals had a mean cost of residency training of \$81,822, with a standard deviation of \$30,297 and a range of \$29,042 to \$183,369, suggesting a wide disparity in costs within a single geographic area where the cost of living should be relatively constant.

Cost of living is not the only factor that might explain the payment or cost differences across hospitals. An alternative hypothesis is that there are economies of scale or diseconomies of scale in residency training. Table 3 shows the relationship between the number of residents and total cost per resident. The results suggest that there is no consistent relationship between a hospital's number of residents and its cost per resident.

Other hypotheses to explain the variation in costs per resident are the presence of systematic variations by region of the country, payer mix, and size of the hospital. The results presented in Table 4 suggest that only a small proportion of the cost and payment differentials is systematically related to any of these factors. The major differences

Table 4

Additional Factors That Could Explain Differences in Total Costs per Resident among 1,185 U.S. Hospitals in Fiscal Year 1991

Hospital Characteristics	Total Cost per Resident
Census region	
New England	\$58,297
Mid Atlantic	\$69,430
South Atlantic	\$57,621
East North Central	\$53,373
East South Central	\$50,109
West North Central	\$56,385
West South Central	\$44,675
Mountain	\$46,558
Pacific	\$53,541
Ownership	
Public	\$61,325
Nonprofit	\$57,569
For-profit	\$38,758
Percentage of revenue from Medicare	
≤ 30%	\$53,400
> 30%	\$57,893
Medicare disproportionate share status	
≤ 15%	\$56,290
> 15%	\$58,850
Bed size	
< 300 beds	\$54,085
300-499 beds	\$59,457
> 500 beds	\$62,118

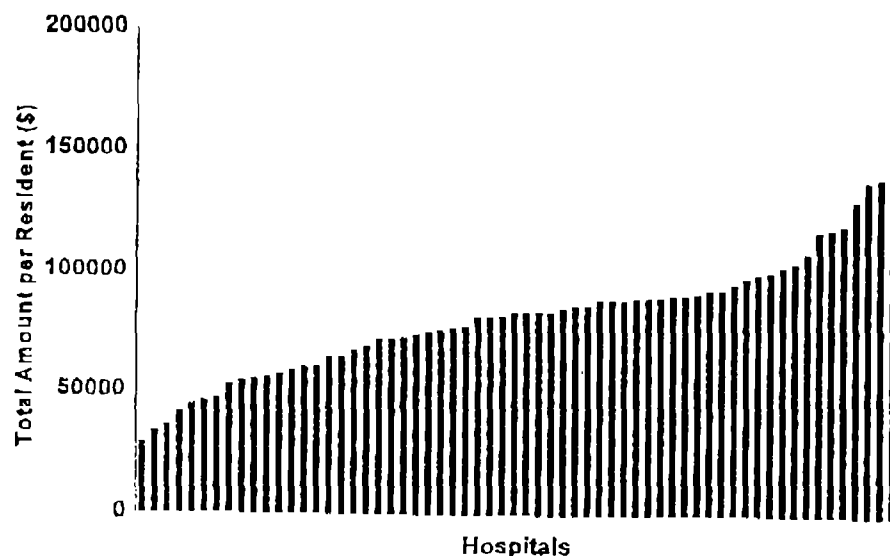


Figure 1. Distribution of costs per resident for the 50 hospitals in New York City with residency programs, fiscal year 1991.

between groups were that costs were higher in certain census regions, lower in for-profit hospitals, and higher in hospitals with more beds. No major difference was found between hospitals that generated more than 30% of their revenues from Medicare compared with hospitals that generated less than or equal to 30%, or between hospitals that had disproportionate-share status above and below or equal to 15%.

I also performed multivariate analyses to determine whether the cost variation could be explained by examining these factors in combination. As the bivariate tables suggest, none of the individual factors was an important predic-

tor of the variation in the costs per resident in the multivariate analyses (data not presented).

I also examined what components of total cost per resident were responsible for the variation. Table 5 shows the distribution of costs attributable to resident stipends only. Comparing Tables 2 and 5 suggests that some of the variation in total cost per resident is attributable to resident stipends and some is attributable to differences in the amounts allocated to other costs, including attending-physician stipends and administration of residency training (costs of malpractice insurance, administrative salaries, office space, teaching materials, etc.). The mean cost attributable to resident stipends was \$31,872, or 56% of the total cost of residency training. The coefficient of variation (mean divided by standard deviation) was actually larger for resident stipends than for total costs, suggesting that resident stipends were more variable than other costs such as faculty salaries.

It is recognized that certain hospitals train high percentages of non-generalists, subspecialists, and fellows, while other hospitals concentrate mainly on training generalists. Because resident stipends vary by year of residency, it is anticipated that hospitals that have higher percentages of residents in the later years of training will have higher

average stipends, which in turn could affect the total cost of training. Unfortunately, I could not obtain data on the numbers of residents in each year of training for all hospitals in the United States. Instead, I obtained these data for 197 hospitals that participated in the two AAMC surveys mentioned above. Using the AAMC data, I computed national average stipends for each year of residency and then calculated the average stipend for each hospital in the survey, assuming that the hospital paid each resident the average stipend for each year. The results suggest that very little of the cost variation can be attributed to differences in the average numbers of years of training across hospitals. Among the 197 hospitals in the sample, the average stipend payment when adjusted by year of training varied by only 5%. This suggests, at least for this sample of hospitals, that distribution of residents by year of training is rather uniform and, therefore, is not a major factor in explaining the cost variation.

The AAMC found that 94.2% of 328 responding hospitals paid the same stipend to all residents regardless of specialty.¹⁰ This suggests that specialty mix does not have a significant impact on resident stipends. The mix of residents, however, could influence the overhead and supervisory-physician costs, since certain specialties may require more supervision.

DISCUSSION

While there is considerable variation in the costs of training residents and the amounts that Medicare pays hospitals for residency education, the factors examined in this study did not explain much of the variation. Differences attributable to number of residents at the hospital, census region, ownership of the hospital, payer mix, and bed size were examined, and relatively small differences between categories of hospitals were found. Cost-of-living indices were not found to be highly correlated with

cost or payment differences. Multivariate analyses confirmed the bivariate analyses that are presented. Although it is commonly believed that differences in how faculty and institutional costs are allocated are responsible for most of the cost variation, the results presented in Tables 2 and 5 show that variations in the amounts paid for resident stipends are responsible for more of the variation than the amounts paid for supervisory physicians and overhead associated with residency training.

These findings reinforce the previous assertions that most of the variation occurs in how hospitals allocate costs for administering residency education.^{1,2,5} It has been suggested that this variation occurs because hospitals use a variety of mechanisms to fund graduate medical education and not because the production processes or input costs are fundamentally different. In some states, for example, residency education is subsidized by state and local governments, while in some institutions faculty practice plans provide an alternative source of income. Access to these funding sources could diminish the necessity for some institutions to aggressively allocate as many costs to residency training as possible. While this could explain why some institutions report higher costs than other institutions, it does not explain variations in the "true" costs of administering residency training.

Despite HCFA's attempt to develop a method for completing Medicare cost reports that would assure comparability across hospitals, hospitals had considerable flexibility in 1984, when they completed the Medicare cost reports that form the basis for the payment rates that are used in 1995, and they continue to have flexibility in how they complete the Medicare cost reports. Hospitals and attending physicians have considerable flexibility between Part A and Part B with respect to how they charge for attending-physician time when they are educating residents. There is flexibility in how malpractice insurance costs, administrative salaries, office space, teach-

Table 5

Distribution of Resident Stipends for 1,185 U.S. Hospitals in Fiscal Year 1991	
Dollars	No. of Hospitals
0-19,999	340
20,000-39,999	511
40,000-59,999	226
60,000-79,999	65
80,000-99,999	16
100,000-149,999	18
150,000-199,999	7
200,000+	2
MEAN	\$31,872
MEDIAN	\$31,036
STANDARD DEVIATION	\$26,547

ing materials, etc., are allocated. These accounting differences could explain much of the reported variation in the costs of training residents. From the available data it is impossible to determine whether more resources are actually allocated to hospitals that report higher costs.

It is also possible that one or more factors are missing from the analysis that could explain some of the variation. One possible factor is the quality of residency education. However, without an explicit measure of the quality of residency education, it is difficult to examine the relationship between this factor and cost. A comparison of the cost per resident and my own assessment of the competitiveness of residency training in various cities could not detect any systematic relationship. In many geographic areas, the most prestigious hospitals were in the bottom half in terms of total cost per resident.

Another possible factor is site of training. Bentley and colleagues¹¹ suggest that training in an ambulatory setting is more costly than training in an inpatient setting because of lower productivity. However, Kearl and Mainous¹² were unable to document differences in physician productivity with and without residents, and an earlier review of the literature¹³ was unable to find any definitive studies of whether physicians in ambulatory settings were less productive when residents were involved.

One limitation of the present study is that it relied on Medicare cost reports to measure the costs of training. This ignores the effect of residency education on physician productivity and physician costs.^{11,14-16} It also ignores the effect of residents on hospital personnel.¹⁷ It also assumes that the reported costs accurately measure the full costs of administering residency training. While Medicare cost reports may not fully reflect the costs of training residents, it should be noted that hospital-

specific costs in 1984 are currently used to set hospital payment rates and, therefore, they do have considerable public policy significance. Certain hospitals receive considerably more than other hospitals from the Medicare program for training residents because of this payment system.

CONCLUSION

Institutions should examine their costs of administering residency training and compare them with the costs at other institutions. The results presented here suggest that comparisons can be made without adjusting for differences in cost of living, type of program, affiliation of hospital, or other factors.

A national payment rate for residency training should be given careful consideration. Replacing the current Medicare payment system, which allocates Medicare payments based on 1984 costs, with a national payment rate would benefit certain hospitals and penalize other hospitals. I have been able to explain only a small proportion of the current variation in the costs of residency training. With the current Medicare payment system certain hospitals are receiving three or four times as much to train a resident as are other hospitals. Differences in the costs of producing a resident should be examined further, and if no systematic differences in the cost of training a resident are found, then movement toward a national rate is warranted. The need for a national rate will be especially compelling if Congress decides to subsidize the cost of training residents as part of health care reform.

REFERENCES

1. Sullivan LS. A Recommendation for a National Per Resident Amount for Medicare Direct Graduate Medical Education Payments: Report to Congress. Washington, DC: Department of

Health and Human Services, 1990.

2. Boex JR. Factors contributing to the variability of direct costs for graduate medical education in teaching hospitals. *Acad Med.* 1992;67:80-4.
3. Physician Payment Review Commission. Chapter 4, Refunding graduate medical education. In: Annual Report to Congress. Washington, DC: PPRC, 1993.
4. American Health Security Act: H.R. 1200: Title III, Subtitle A, Subpart C, Section 3031, 1993. Washington, DC: U.S. Government Printing Office, 1993.
5. Anderson GF, Lave JR, Russe CM, Neuman P. Providing Hospital Services: The Changing Financial Environment. Baltimore, MD: The Johns Hopkins University Press, 1989.
6. Mullan F, Rivo ML, Politzer RM. Doctors, dollars, and determination: making physician workforce policy. *Health Aff.* 1993;12(Suppl):138-51.
7. Brown JG. A Study of Graduate Medical Education Costs, DHHS Publication No. A-09-93-00096. Washington, DC: Office of Inspector General, Department of Health and Human Services, July 1994.
8. Fed Reg. 1991 Nov. 25;56(227):59632-819.
9. Prospective Payment Assessment Commission. Report and Recommendations to Congress. Washington, DC: ProPAC, March 1, 1993.
10. Association of American Medical Colleges. Council of Teaching Hospitals Survey of Housestaff Stipends, Benefits and Funding, 1993. Washington, DC: AAMC, 1993.
11. Bentley JD, Knapp RM, Petersdorf RG. Education in ambulatory care—financing is one piece of the puzzle. *N Engl J Med.* 1989;320:1531-4.
12. Kearl GW, Mainous AG III. Physicians' productivity and teaching responsibilities. *Acad Med.* 1993;68:166-7.
13. Lave JR, Institute of Medicine. Primary Care Physicians: Financing Their Graduate Medical Education in Ambulatory Settings. Washington, DC: National Academy Press, 1989.
14. Feigenbaum S, Anderson GF, Lave JR. Medicare's prospective payment system: the victim of aggregation bias? *Rev Economics Statistics.* 1992;74(1):185-91.
15. Mulhausen R, Kaemmerer C, Foley J, Schultz A. Education costs in two public teaching hospitals. *Acad Med.* 1989;64:314-9.
16. Welch WP. Do all hospitals deserve an add-on payment under the prospective payment system? *Inquiry.* 1987;24(Fall):221-32.
17. Dolan KL, Rosner F, Spiegel K. Survey of non-physician tasks performed by medicine residents at a municipal hospital. *J Natl Med Assoc.* 1990;82:629-33.

*Sandy
right
Feder
Plans*

are allocated. These differences could explain reported variation in the costs to residents. From the data it is impossible to determine whether more resources are actually allocated to hospitals that report

specific costs in 1984 are currently used to set hospital payment rates and, therefore, they do have considerable public policy significance. Certain hospitals receive considerably more than other hospitals from the Medicare program for training residents because of this payment system.

CONCLUSION

Institutions should examine their costs of administering residency training and compare them with the costs at other institutions. The results presented here suggest that comparisons can be made without adjusting for differences in cost of living, type of program, affiliation of hospital, or other factors.

A national payment rate for residency training should be given careful consideration. Replacing the current Medicare payment system, which allocates Medicare payments based on 1984 costs, with a national payment rate would benefit certain hospitals and penalize other hospitals. I have been able to explain only a small proportion of the current variation in the costs of residency training. With the current Medicare payment system certain hospitals are receiving three or four times as much to train a resident as are other hospitals. Differences in the costs of producing a resident should be examined further, and if no systematic differences in the cost of training a resident are found, then movement toward a national rate is warranted. The need for a national rate will be especially compelling if Congress decides to subsidize the cost of training residents as part of health care reform.

REFERENCES

1. Sullivan LS. A Recommendation for a National Per Resident Amount for Medicare Direct Graduate Medical Education Payments: Report to Congress. Washington, DC: Department of

Health and Human Services, 1990.

2. Boxer JR. Factors contributing to the variability of direct costs for graduate medical education in teaching hospitals. *Acad Med.* 1992;67:80-4.
3. Physician Payment Review Commission. Chapter 4. Reforming graduate medical education. In: Annual Report to Congress. Washington, DC: PPRC, 1993.
4. American Health Security Act: H.R. 1200: Title III, Subtitle A, Subpart C, Section 3031, 1993. Washington, DC: U.S. Government Printing Office, 1993.
5. Anderson GF, Lave JR, Russe CM, Neuman P. Providing Hospital Services: The Changing Financial Environment. Baltimore, MD: The Johns Hopkins University Press, 1989.
6. Mullan F, Rivo ML, Politzer RM. Doctors, dollars, and determination: making physician workforce policy. *Health Aff.* 1993;12(Suppl):138-51.
7. Brown JG. A Study of Graduate Medical Education Costs. DHHS Publication No. A-09-93-00096. Washington, DC: Office of Inspector General, Department of Health and Human Services, July 1994.
8. *Fed Reg.* 1991 Nov. 25;56(227):59632-819.
9. Prospective Payment Assessment Commission. Report and Recommendations to Congress. Washington, DC: ProPAC, March 1, 1993.
10. Association of American Medical Colleges. Council of Teaching Hospitals Survey of House-staff Stipends, Benefits and Funding. 1993. Washington, DC: AAMC, 1993.
11. Bentley JD, Knapp RM, Petersdorf RG. Education in ambulatory care—financing is one piece of the puzzle. *N Engl J Med.* 1989;320:1531-4.
12. Kearl GW, Mainous AG III. Physicians' productivity and teaching responsibilities. *Acad Med.* 1993;68:166-7.
13. Lave JR, Institute of Medicine. Primary Care Physicians: Financing Their Graduate Medical Education in Ambulatory Settings. Washington, DC: National Academy Press, 1989.
14. Feigenbaum S, Anderson GF, Lave JR. Medicare's prospective payment system: the victim of aggregation bias? *Rev Economics Statistics.* 1992;74(1):185-91.
15. Mulhausen R, Kaemmerer C, Foley J, Schultz A. Education costs in two public teaching hospitals. *Acad Med.* 1989;64:314-9.
16. Welch WP. Do all hospitals deserve an add-on payment under the prospective payment system? *Inquiry.* 1987;24(Fall):221-32.
17. Dolan KL, Rosner F, Spiegel K. Survey of non-physician tasks performed by medicine residents at a municipal hospital. *J Natl Med Assoc.* 1990;82:629-33.

Sandy Is this right for the Federal Register? Please let us know

Tuesday
11/24/98

9:15 - Conf. Call w/Darla
She will call here

12:00 - Conf. Call "World AIDS Day"
w/S. Bianchi, T. Summers,
S. Thurman, L. Boeder, L. Summey
Call 456-6766 Code 4725

1:00 - Health Policy Conf. Call
456-6755/66766 Code 4725

2:00 - Mtg w/ Tony Podesta
Chris' ofc.

4:00 - Conf. Call w/Jim Tallon
"Status of Quality Forum"
456-6755 Code 4725

5:00 - Children's Hospital mtg
w/B. Woolley, J. Klein
Room 211

Revised: 9:00am-11/24

Revised: 11:00am-11/24

PROBLEMS WITH THE KERREY PROPOSAL

Senator Kerrey has introduced a proposal to provide freestanding children's hospitals with funding for their graduate medical education (GME) costs. This proposal uses general appropriation funds to distribute GME funds based upon a formula that is similar to the Medicare formula currently used. Children's hospitals would receive GME funds for costs associated with both direct and indirect medical education. The proposal provides the Secretary with the authority to limit the expenditures under this proposal to the amount specified in statute; if the appropriation is insufficient to provide the total payments that are due to the children's hospitals, she must reduce the amounts paid to the hospitals.

There are several problems with the Kerrey proposal as currently drafted. These include:

- **Making the government entirely responsible for the cost of direct medical education (DME).** Currently, the government only assumes the percentage of the DME costs associated with providing care to Medicare patients. Under the Kerrey proposal, children's hospitals would receive DME reimbursement based on a flat per resident amount, without consideration for the percentage of their expenditures associated with providing care to Medicare or Medicaid patients. As currently drafted, the Federal government would be required to provide approximately \$76,000 per resident for DME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs.
- **Providing indirect medical education (IME) reimbursement that does not account for additional costs associated with training.** Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because of the greater number of tests ordered by interns and residents and other inefficiencies associated with inexperience. Teaching hospitals receive indirect medical education payments to account for these costs. Under the Kerrey proposal, children's hospitals would receive a per resident amount that would not consider the additional costs associated with training physicians. As currently drafted, the Federal government would be required to provide approximately \$70,000 per resident for IME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs.
- **Administering the cap on GME payments to these hospitals will be difficult.** The Kerrey proposal requires the Secretary to limit the expenditures under this proposal to the amount specified in statute; if the appropriation is insufficient to provide the payments due to the children's hospitals, she must reduce the amounts disbursed. As the proposal is currently drafted, it is clear that the Secretary will be forced to reduce the payments to the hospitals. The formulas provide the children's hospitals with approximately \$215 million for DME and \$244 million for IME, for a total of \$459 million in GME payments. However, the Kerrey proposal caps GME payments at \$285 million per year. This would place the Department in the position of having to reduce the funds provided on a retrospective basis which would be extremely difficult if not impossible.

PROVIDING FEDERAL FINANCING FOR GRADUATE MEDICAL EDUCATION PROVIDED BY FREESTANDING CHILDREN'S HOSPITALS

SUMMARY

This proposal would provide freestanding children's hospitals with Federal financing for graduate medical education commensurate to that received by other teaching hospitals. Attached are four options to address the current inequities in financing. (Cost: depending on option chosen, \$50 to \$285 million).

BACKGROUND

- **The Federal government has traditionally provided teaching hospitals with financial support for graduate medical education.** Care in teaching hospitals is generally recognized as costlier than similar care provided in non-teaching facilities, because the inefficiencies associated with inexperience and a sicker patient population. Because a competitive health care market dominated by managed care is often unwilling to assume the costs of graduate medical education, the Federal government has assumed a portion of the cost of these training activities. These medical education payments allow teaching hospitals to maintain their academic mission without sacrificing their financial health.
- **Freestanding children's hospitals train the majority of essential pediatric providers.** The children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. Since there are physician shortages in some areas of pediatric subspecialty care, these hospitals are critical to maintaining an adequate practitioner supply.
- **Although children's hospitals share the academic mission of other teaching hospitals, they are denied a commensurate level of Federal support.** The current system of Federal reimbursement for graduate medical education is dependant on the number of Medicare patients seen, creating a significant competitive disadvantage for children's hospitals. Teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident received by children's hospitals.
- **Alternate sources of GME financing are ending.** Children's hospitals in some States receive GME funding through the Medicaid program. However, as more States move to Medicaid managed care programs, Medicaid is no longer a viable source of funding for these providers. Managed care competitive point here
- **Children's hospitals sustain significant financial losses because of their GME activities.** Despite the fact that children's hospitals maintain a significant pediatric market share, their patient care revenues are falling short of covering their patient care costs. Children's hospitals operating margins are -6.2 percent, as opposed to -3.9 percent for other teaching hospitals. A significant percentage of this loss is attributable to unreimbursed GME costs, which run in the millions of dollars per year per hospital.

- **Many children's hospitals are financially vulnerable.** The inequity in Federal financing forces children's hospitals to depend on non-patient care revenue to a greater extent than other teaching hospitals. Children's hospitals receive almost 15 percent of their total funding from revenues unrelated to patient care. Other teaching hospitals only receive 8.6 percent of their revenue from these sources. This makes children's hospitals more vulnerable to an economic downturn that could threaten their financial health.

POLICY OPTIONS

NOTE: All of these options except Option Four will be funded through a capped mandatory grant program.

Option 1: Modify the Kerrey proposal to provide reimbursement for those GME costs associated with providing care to publicly insured patients.

The Kerrey proposal provides the children's hospitals with DME reimbursement based on a flat per resident amount, without consideration for the percentage of their expenditures associated with providing care to Medicare or Medicaid patients. Under this option, children's hospitals will only receive reimbursement for the portion of their DME and IME expenses associated with providing care to ~~Medicare and Medicaid~~ patients. The Kerrey proposal distributes IME payment as an average payment per resident. Indirect medical education is paid as a percentage add-on to the payment for a Medicare discharge. Under this option, we would modify the Kerry proposal to provide an IME adjustment to the payment made for a Medicaid ~~or Medicare~~ patient. This option would also have the Secretary prospectively limit the funds disbursed to the amount appropriated, rather than recover overpayments retrospectively. (Cost: unclear. HCFA is developing estimates.)

Option 2: Eliminate IME reimbursement from the Kerrey proposal.

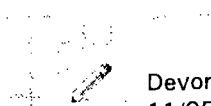
The Kerrey proposal requires the Federal government to provide approximately \$76,000 per resident for DME costs alone. This is as much as we presently provide to other teaching hospitals for both their direct and indirect medical education costs. The proposal could be modified to exclude reimbursement for IME and reimburse for only DME costs. This would provide the children's hospitals with the commensurate funding they are seeking while making limited changes to the Kerrey proposal. The proposal would include a provision that would require the Secretary to prospectively limit the funds disbursed to the amount appropriated. Funds could be placed in an account that would close when tapped out, or the Secretary could hold back a percentage of each hospital's funds to protect themselves from going over the cap and having to recoup funds. This option would perpetuate the flaw in the DME formula. (Cost: \$285 million)

Option 3: Require Medicare to disburse GME funds based on a flat, per resident amount.

This proposal would provide children's hospitals with graduate medical education funding according to a flat, per resident amount adjusted for geographic variation in health care costs that would be determined by HCFA and disbursed through the current GME reimbursement system used by HCFA. The amount of funding an institution received would be dependant solely on the number of residents it had enrolled. There would be a cap on the amount of funds that could be disbursed. This is a simpler formula than the Kerrey proposal and essentially has the same distributional effects. However, the children's hospitals may prefer the formula to resemble the one used to distribute funds to other teaching hospitals. (Cost: \$285 million)

Option 4: Create a discretionary grant program to provide GME funds through the PHS.

This option could use either the Kerrey formula or the flat, per resident distribution formula. Alternatively, it could require children's hospitals to submit an application to receive a GME grant. Potential grantees would submit a summary detailing the extent of their financial need, an overview of their curriculum and training, and their previous experience in providing graduate medical education. Based on Federal review of the grant proposal, hospitals could receive different levels of funding. (Cost: could vary, depending on funds available.)



Devorah R. Adler
11/05/98 02:52:00 PM

Record Type: Record

To: Sharman Stephens <SStephens @ hcfa.gov>

cc:

Subject: Re: GME and children's hospitals -Reply -Reply 

here you go

Hello -

Folks over here have expressed interest in exploring options to provide free standing children's hospitals with graduate medical education payments commensurate with those recieved by other teaching hospitals and academic medical centers.

It would be great if we could meet sometime this week -- does Thursday 11/5 at 3 pm sound good? -- to discuss options around this issue.

I have set up a conference call line -- 456 6766, code 7923. Please let me know if this doesn't work for you and we'll set up something else.

Thanks a lot --

Devorah
456 5707

Sharmau
Caroline
mark H.
Julie Sol

OPTIONS

1. KERRY w/ modifications:

- Medicare Share
- Resident Cap
- ~~At~~ Prospective, Not Retrospective

2. MEDICARE DISTRIBUTION of
A Per Resident /

~~By~~ 2001

CONTEXTUAL : MEDICARE:

PROVIDING ADDITIONAL GRADUATE MEDICAL EDUCATION (GME) FUNDING TO CHILDREN'S HOSPITALS

Option One: Creating a New Disbursement Formula

This proposal uses general appropriation funds to provide GME funds to children's hospitals based upon a formula that is similar to the Medicare formula currently used to disburse GME funds. Children's hospitals would receive GME funds for costs associated with both direct and indirect medical education. The proposal provides the Secretary with the authority to limit the expenditures under this proposal to the amount specified in statute; if the appropriation is insufficient to provide the total payments that are due to the children's hospitals, she must reduce the amounts paid to the hospitals. This proposal was introduced in the Senate in May of 1998. (Cost: \$100 million the first year; \$285 million each succeeding year.)

Option Two: Using an Institution Specific, Per Resident Rate

This proposal would develop institution specific, per resident rates using methodology similar to that presently used by the Veterans Administration. [I don't have information on this but will get it in the morning.]

Option Three: Developing a Medical Education Trust Fund

This proposal would establish a medical education trust fund from which payments would be made to teaching hospitals for both their direct and indirect medical education expenditures. [I looked at this one, and am not sure that it applies -- probably because I don't understand Medicare. See my notes on the copy of the bill.]

Could be for

Option Four: Expanding Current State Options in Medicaid

Although there is no requirement that States make Medicaid GME payments, many States do make additional payments to hospitals with GME programs, in recognition of the higher costs associated with providing services to Medicaid patients treated in these facilities. Federal matching funds are available for GME expenditures for Medicaid patients. This proposal would require States to provide GME funds to teaching hospitals treating Medicaid patients and increase the Federal match for these expenditures to 100 percent. Funds would be disbursed through a mechanism similar to the one used in Medicare. [When I get the GAO report and additional information, I bet we can make this option better.]

Option Five: Modifying the GME Consortium Demonstration Project

The BBA provided the Secretary with the authority to establish a GME consortium demonstration project. A consortia is defined as a teaching hospital working in conjunction with a variety of different provider entities. Children's hospitals can participate in these consortium projects. Presently, the amount of funding the consortium can receive is limited to the amount the teaching hospital would have received otherwise. This proposal would remove that requirement, allowing for more flexibility in the distribution of funds to consortia members. This proposal would be funded by the Medicare trust fund.

Option Six: Modifying the Existing Formula Allocating GME Funds

This proposal would change the formula currently used to allocate GME funds so that it no longer included Medicare specific variables (rather than using the number of Medicare bed days in the calculation, it would use total number of bed days). This proposal would be funded by the Medicare trust fund.

Option Seven: Separating the Indirect Costs of Medical Education From Reimbursement Rates

This proposal would develop a formula to determine the level of additional resources required by children's hospitals to support functions beyond ordinary patient care. *and distribute those funds to children's hospitals accordingly.*



FAX from Bill Pike, WNYHA

TO: Chris Jennings, Deputy Assistant to the President for HealthCare Policy ✓
Barbara Woolley, Associate Director, White House Office of Public Liaison

DATE: 12/17/98

Fax Number: 695-0073
Phone Number: 695-0843, VM Ext. 208
E-Mail Address: bpike@wnyha.com

Number of Pages
(including cover) 2

MESSAGE:



WESTERN NEW YORK HEALTHCARE ASSOCIATION

December 17, 1998
William D. Pike
President

Honorable William Jefferson Clinton
President
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear President Clinton:

It is our understanding that you are considering the possibility of making new Medicare and/or Medicaid cuts in your FY2000 budget proposal. I write on behalf of more than 53 hospitals, health systems, nursing homes, and home care agencies in Western New York to express our strong opposition to the inclusion of any new Medicare or Medicaid spending cuts, including the user fees, reductions in Medicaid and Child Health administrative funds, and delays in annual provider payment updates that were proposed during 1998.

We also strongly oppose the inclusion of any new direct provider payment cuts, such as the extension of the hospital marketbasket update cuts in the Balanced Budget Act (BBA), which we understand may be under consideration.

Health care providers in Western New York have yet to face approximately 85 percent of the payment cuts mandated by the BBA. Medicare payments to WNY hospitals will be reduced by over \$256 million over the five year period defined by the BBA. These tremendous reductions do not include the reductions in nursing home, home care, and other provider payments that are included in the BBA.

As a result of these reductions, many hospitals, health systems, nursing homes, and home health agencies in New York are losing money treating Medicare patients in the inpatient, outpatient and continuing care settings. These Medicare losses across the continuum will continue to grow as additional BBA provisions are implemented. Making additional reductions could jeopardize health care services in our communities. It is estimated that our WNY hospitals will lose more than \$30 million this year alone (from operations).

As the Administration finalizes its FY2000 budget proposal, we hope you will join with us in rejecting any new Medicare and Medicaid cuts. Over the last several years, we have worked together to strengthen and improve the Medicare and Medicaid programs. Making new cuts could undermine the progress we have made together.

Sincerely,

William D. Pike
President

1876 Niagara Falls Boulevard Tonawanda New York 14150-6499
(716) 695-0843 Fax (716) 695-0073

BACKGROUND

Since 1965, Medicare and, to a lesser extent, Medicaid have played a key role in financing graduate medical education (GME). About 74 percent of Federal outlays for GME is through Medicare, and 19 percent through Medicaid (MEDPAC, March 1998). Medicare payments consist of two components. The first payment, direct graduate medical education (DGME), covers Medicare's share of costs directly associated with operating resident training programs. Medicare's DGME payments are estimated to be \$2.580 billion in federal fiscal year (FY) 1998. The second component recognizes the indirect costs of graduate medical education (IME) and is an adjustment consisting of a percentage added-on to the amount that Medicare would otherwise pay the hospital for each Medicare in-patient treated. Medicare IME payments are estimated to be \$5.337 in FY 1998. Over five years (FY 1999-2003), the HCFA's Actuary estimates that Medicare Part A spending on direct and indirect medical education will equal \$51.9 billion. (Over the same period, CBO estimates that GME spending would equal \$29.3 billion.) Medicare also makes payments to hospital operated nursing and allied health education programs on the basis of Medicare's share of the hospital's costs of these educational activities. Nursing and allied health education payments are estimated to be around \$400 million in FY 1998.

ISSUE

Medicare Part A bears the primary burden of financing direct and indirect medical education. However, an argument can be made that medical education is a societal benefit -- everyone benefits from medical training -- and that these payments should not be made by Medicare alone. Because of the concern about the future status of the Medicare Part A Trust Fund (currently the source of funds for Medicare GME payments), the equity issue of Medicare being the major financing source becomes even more compelling.

There have also been concerns that as the health system changes with more beneficiaries in both Medicare and Medicaid moving into managed care, and more care being delivered on an outpatient basis, the current allocation of funding through Medicare and Medicaid hospital payments may not be responsive to the "social good" policy objectives in terms of training the right mix of specialties and providing support for academic health centers.

Questions have also been raised about Medicare support for nursing and allied health education. Diploma nursing schools operated by hospitals was the predominant form of nursing education in the 1960's when Medicare was enacted. However, most nursing education today takes place baccalaureate and advanced degree nursing programs which are operated by colleges and universities. Over time, many of the diploma schools have closed. However, since Medicare supports hospital-operated nursing schools, most of Medicare's payment for nursing and allied health education is for diploma nursing education. The concern has been raised as to whether Medicare should discontinue its support diploma nursing education and focus on providing support for graduate nursing education (nurse practitioners,

clinical nurse specialist, certified nurse mid-wives) who are better qualified for practice in community settings than diploma nurses graduating from hospital-operated schools.

PROPOSAL:

Remove GME (direct and indirect) from Medicare Part A. The removal of GME from Medicare Part A financing, however, raises three major areas for policy discussion.

How to Finance

If GME expenditures are removed from the Part A Trust Fund there are three broad options for funding graduate medical education.

1. **Finance through general revenues and subject GME to the discretionary appropriations process.** Support through general revenues recognizes that all people benefit from support of graduate medical education. Under this approach, however, GME funding would have to compete annually with other spending priorities as part of the discretionary appropriations process, and this could make it easier to reduce spending on medical education. Any reduction in spending on graduate medical education would be likely to encounter political resistance.
2. **Transfer spending to Medicare Part B and Continue GME "entitlement" status.** Since 75 percent of Part B funding comes from general revenue, this would at least spread the costs of graduate medical education across a broader pool of taxpayers. This approach to GME funding under Part B would maintain its mandatory spending nature and would not provide for an annual discussion of the "right" level of spending. The transfer to Part B, however, would result in an increase in Medicare beneficiaries premiums, raising a somewhat different equity issue of why only Medicare beneficiaries directly bear a cost of GME.
3. **All-Payer Pool / Self-funded Trust Fund.** A graduate medical education trust fund (or all-payer pool) would recognize that everyone benefits from GME and IME payments, not just Medicare beneficiaries. Moving this funding out of Medicare completely may make it easier to require other contributions to help fund graduate medical education (e.g., through contributions from all-payers). For purposes of the Federal contribution on behalf of Medicare and Medicaid a decision would need to be made as to whether the public share came from general revenue appropriations or came as a special payment from the Medicare trust fund(s). If necessary, a combined approach could be used where in addition to a payment from Medicare, general funds also could be appropriated to the trust fund, similar to the funding for the graduate medical education trust fund proposed by Congress in the vetoed balanced budget bill (Fall, 1995).

How Much

1. **Current Level of Financing.** Medicare payments for DGME, IME and nursing and allied health education in FY 1998 are estimated to be nearly \$7.5 billion. The level of financing could be set equal to Medicare's projected expenditures for graduate medical education and nursing and allied health education. These payments could be adjusted to take into account that Medicare may be supporting the training of more physicians than are needed for practice or the balance of the funding could be dedicated to establish a set-aside to provide for payment to new programs, especially in non-traditional sites, and for programs in providers with very low Medicare utilization. In this way, GME funding could become available to institutions that could not qualify for significant funding under Medicare rules, such as Children's Hospitals. These funds could also be used for demonstration projects, or in a variety of other ways to provide incentives for the type of training that will be needed to create the best medical workforce for the future. This option requires the least change in financing streams and would not need to be supported by new revenues since under budget scoring rules, substitution of one mandatory funding requirement for another has no budgetary impact even if the financing mechanism changes (e.g. general revenues are substituted for payroll taxes).
2. **Supplement Medicare Financing.** Negotiating higher funding levels are also an option to provide a level of funding that approximates what all payers should contribute to such support. Any additional funding beyond what Medicare currently gives would require a new revenue source (i.e. a tax) or offsets in discretionary spending. The discussions of GME Trust Funds in the vetoed legislation, particularly those funded by general revenues, usually assumed an increase in overall GME funding by the Federal Government; that is, that the general revenue funding would be in addition to Medicare GME funding. General revenue funding could also be directed towards achieving some of the goals (i.e. financing training in Children's Hospitals) described above. Although the goal for a GME Trust Fund may ultimately be to establish a level of financing which approximates that which would occur under an all-payer system, recent discussions have not focused on requiring contributions to the all-payer pool from private health insurers.

Method of Allocation / Options

The GME Trust Funds should be distributed consistent with the following goals:

- The nation's health workforce should be as diverse as the nation's population in order to help meet the service needs of vulnerable and diverse populations.
- The nation's health workforce should be more equitably distributed in order to provide reasonable access to care for all Americans.
- Certain components of the health workforce should be augmented while other components should be reduced in order to provide balanced access to care for

certain Americans.

- The settings for health workforce education and training should be reflective of the settings in which services are delivered to assure that the health workforce is competent. The content of training should be reflective of the care needs of the population.

It is commonly recognized that Medicare payment formulae have not adequately fostered these goals. However, Medicare policy may be better aligned with achieving these goals as a result of changes made under the Balanced Budget Act.

1. **Distribute the GME Trust Fund money based on current Medicare policies.** The Balanced Budget Act made changes to Medicare financing of graduate medical education which may help achieve some of the above listed goals:

- Full Time Equivalent Caps on Medicare Payment. Medicare pays for IME and DGME based on the number of residents in training. This has led to concern that Medicare has provided incentives for hospitals to train more physicians than are needed for practice. The Balanced Budget Act caps the number of residents paid for by Medicare for IME and DGME. This may limit the future rate of increase in physician supply in areas of the country which have a glut of doctors.
- Adjustments to FTE Caps. To help alleviate the problems with the maldistribution of physicians, the Balanced Budget Act provides the Secretary with broad authority to allow for adjustments to FTE caps for new medical residency training programs. Under rules developed last August, hospitals which previously did not have training programs and hospitals in rural areas can establish new medical residency training programs which are allowed to grow for 3 years before the cap is applied.
- Incentives to Downsize Training Programs. The Balanced Budget Act also provides modest incentives for hospitals to reduce the size of residency training programs by providing payment based on a 3 year average count of residents. As hospitals downsize training programs, the payment loss is phased in over a 3 year period.
- Ambulatory Training. Prior to the Balanced Budget Act, hospitals could only count resident training time in nonhospital sites for DGME. However, since IME is typically a much larger payment to the hospital, losing the resident in the IME FTE count provided a major disincentive for hospitals to provide residents with training in nonhospital sites. The Balanced Budget Act allows the hospital to count resident training time in nonhospital sites for DGME and IME if the hospital incurs the cost of the training. It also allows some clinics and

managed care plans to receive DGME from Medicare.

2. **Develop Alternative Payments Methods.** There are a number of ways of distributing DGME and IME funds. For instance, separate average prospective per resident rates which take the current IME and DGME payments could be developed that are paid either to the site of training, the sponsor of the program (which could be a medical school) or even the residents themselves. Payments could be provided under a block grant system related to each institution's percentage of historical Medicare graduate medical education payments. (This plan was part of the vetoed legislation in 1995 and HCFA had major concerns about how to adjust payments to all hospitals when other hospitals which newly participate in training become entitled to payments). Under whatever alternative payment mechanism which is developed, it is important to recognize:

- The alternative formulae would inevitably produce redistributions of graduate medical education payments. The political opposition to the effects of these redistributions might well confound the prospects for establishing a trust fund at all. However, opposition could be mitigated by providing broader public financing for graduate medical education.
- There is no broad consensus supporting specific alternatives that would be a significant improvement. Proposals to allocate funds based on historic Medicare payments do not hold teaching hospitals accountable for meeting trust fund goals and build in current payment inequities. Other proposals continue to link payment to resident counts and provide incentives for increasing the size of residency programs.
- Any significant funding redistributions would require a transition period to moderate the impact.

HCFA issues decision on Med-Peds GME

John Chamberlin, M.D.

The Health Care Financing Administration (HCFA) has issued their final decision and will fund the direct medical education component of the 4th year Med-Peds training at only a 0.5 equivalent rate despite input from a wide variety of sources asking them to reconsider.

HCFA focused on their lack of statutory authority to make an exception for Med-Peds in deference to other combined programs and on the Accreditation Council for Graduate Medical Education (ACGME) definition of a specialty. Since Med-Peds is not defined as a single specialty requiring four years of training followed by a single specific Board exam, HCFA defaulted to the fact that each of the two specialties that contribute to the training of Med-Peds physicians can be completed in three years. Interested readers are encouraged to review HCFA's logic as published in the August 30 *Federal Register*, pgs 46207-46213. It can be obtained by pointing your Web Browser to <http://www.gpo.ucop.edu>.

To put this in perspective, one needs to know a little bit about the funding of graduate medical education. Graduate medical education is funded at both the federal and state levels and funding is divided into indirect medical education expenses (IME) and direct medical education (DME) expenses. In most situations, DME funding is about half of IME funding. The HCFA decision impacts the federal contribution to DME funding in the 4th year of Med-Peds training. The impact this will have varies from program to program as the relative contributions at federal and state levels to DME and IME varies. Early estimates project a decrease in total funding for a four year Med-Peds resident to be from 2% to 20 %, depending on the program, as a result.

Already, one can hear concerns expressed that this will discourage medical students from selecting Med-Peds as a training option and residents are expressing concern about their already conservative salaries. As should be clear from the above projections, HCFA's decision, though disappointing and needing to be reversed, does not spell the demise of Med-Peds.

Med-Peds is a concept whose time has come. Those involved in Med-Peds training programs surely recognize that and none are likely to fold because of HCFA's decision. Graduate medical education faces many challenges in the upcoming years and there will be downward pressures in funding from many directions. Universities and hospitals have to decide which programs they will defend and may be called upon to shift some funding internally. It is unlikely that many programs already involved in Med-Peds training will fail to recognize that, at the end of four years, Med-Peds training produces a superbly trained primary care physician. One would anticipate that Med-Peds would be amongst the last programs to be cut and, certainly, resident salaries would be the last item on the budget to be impacted.

The HCFA issue now lies in the political arena. Congress needs to modify the statute in favor of Med-Peds. There is a tendency to compare politics to the sport of curling (or Eisstockschiessen). In curling, players slide (shoot) cylindrical Eis-stöcken ("ice stocks") down an ice rink, aiming to come as close as possible to a Runddaube ("rubber ring") inside a 6-m (6.6-yd) long area called a house. Players from opposing teams rapidly sweeping the area immediately ahead of the traveling Eisstöcken to influence its course and distance favorably for their team.

Spectators are inclined to think that, although the sweepers seem to be putting in a lot of work, surely, if anything alters the Eisstöcken from its appointed course, it is more likely to be some hidden person with a large magnet or control device. Enthusiasts of the sport point out that isn't so and that the sweepers do influence the course of events. I'm afraid many of us view politics with the same skepticism. We suspect the real power lies beyond our dominion.

Do not minimize the impact you might have on Congress to influence the future funding and direction of

graduate medical education (GME). America will always need high-quality primary care physicians. Perhaps, now more than ever. Funding of GME should not become a contest between the various disciplines that produce primary care physicians. Med-Peds physicians need plead neither superiority nor entitlement. It should be sufficient that Med-Peds training has attracted a bright cohort of very capable students and made them superbly trained primary care physicians. It did so before the national imperative to shift students to primary care.

Late breaking news regarding the HCFA GME funding decision

Congresswoman Louise Slaughter (D-NY) has drafted the bill titled "Primary Care Promotion Act of 1996" which she intends to introduce in the final days of the 104th Congress to be put on the agenda for the 105th Congress in January. This bill will attempt to address the issues of the direct component of GME funding of Med-Peds residents as raised by HCFA. Additional ways that we can support this type of initiative will be forthcoming as information is obtained.

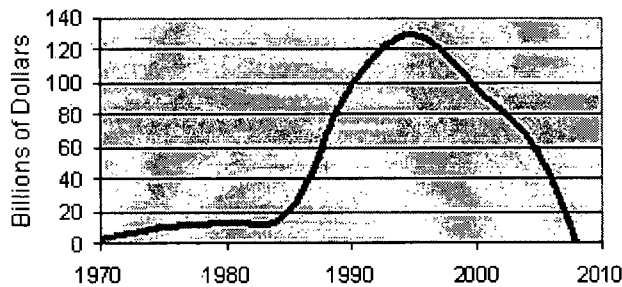
Contact John Chamberlain

National Bipartisan Commission on the Future of Medicare

GO TO: [Medicare HOME](#)

The Facts About Medicare

Part A Trust Fund Goes Bankrupt in 2008



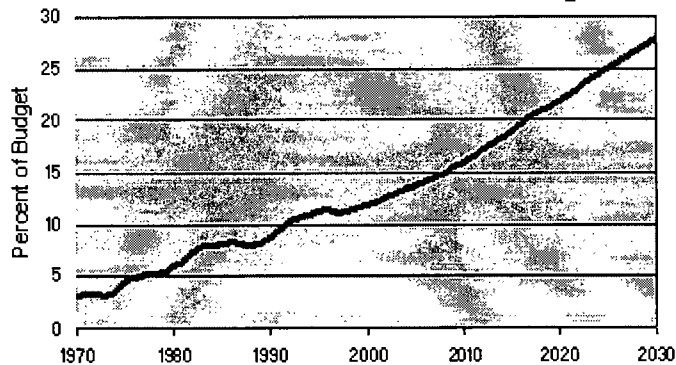
Source: Health Care Financing Administration

→ Fact #1

Medicare Goes Broke in 2008

The Balanced Budget Act of 1997 (which also created the Medicare Commission) ensures solvency of the Medicare Part A trust fund for the next 10 years. But, without reform, the trust fund goes bankrupt in the year 2008.

Medicare Threatens Federal Budget



Source: Congressional Budget Office / National Medicare Commission

→ Fact #2

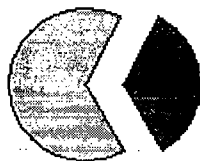
Medicare Spending Threatens Other Programs

Annual Medicare expenditures will climb from \$207 billion, last year, to between \$2. and \$3 trillion by the year 2030. As a result, Medicare spending will become a much larger part of the federal budget, threatening the funding of other important programs such as national defense, justice, health and safety and environmental protection.

Who Pays for Medicare Beneficiaries' Health Care?

Public

67%
Medicare,
Medicaid
and other
public
sources



Private

33%
Out-of-
pocket,
Medigap and
private
employer

Source: 1995 Medicare Current Beneficiary Survey, HCFA

→ Fact #3

Beneficiaries' Out-of-Pocket Costs to Rise

As the Medicare system itself faces financial troubles, Medicare beneficiaries also face higher costs. Today, beneficiaries pay nearly 30 percent of their health care costs from their own pockets. In 1995, those costs averaged \$2,563 per person to pay for premiums, services and products not covered by Medicare. In the future, out-of-pocket costs are expected to rise.

Children's Hospital:

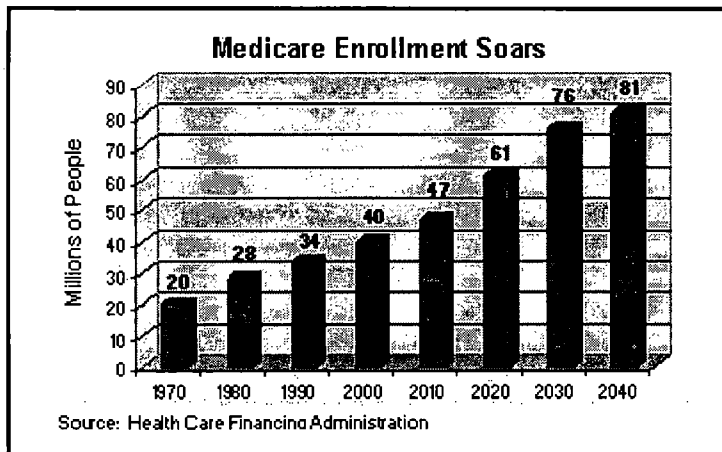
per Resident amount:

Most:

Could use

1. Kerry:

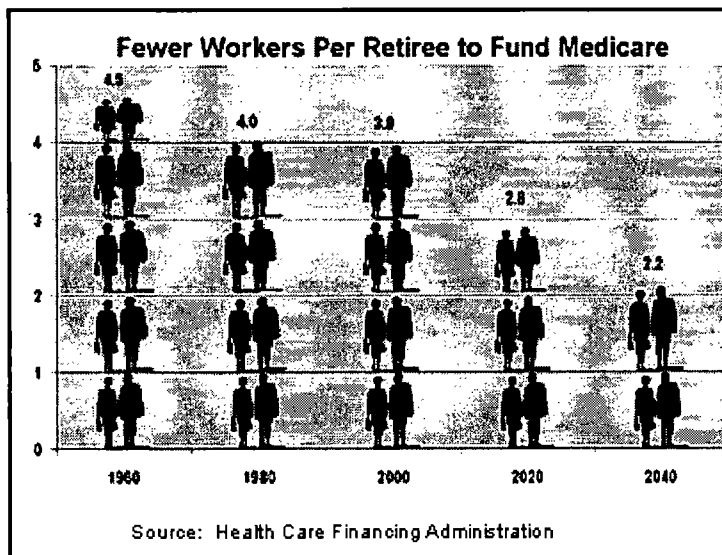
Regional Differen
On CR Wage



➔ **Fact #4**

77 Million Baby Boomers to Enter Medicare

Medicare must be strengthened and improved to handle the increased demand of 77 million "Baby Boomers" (people born between 1946 and 1964) who will begin entering Medicare in the year 2011.



➔ **Fact #5**

Fewer Workers Per Retiree to Fund Medicare

As the number of new Medicare beneficiaries rises sharply, there will be significantly fewer workers per retiree to fund Medicare.

Without fundamental reform solving Medicare's problems would require some combination of:

- severe cuts in benefits
- doubling payroll taxes from 2.9 percent of wages to between 5.6 and 7.7 percent
- dramatically raising income taxes (for example, increasing the 1 percent bracket to an 18-20 percent bracket and the 28 percent bracket to 34-38 percent)
- cutting other vital programs such as national defense, justice, health and safety, and environmental protection
- increasing the national debt

Kerry -

Payments Sum DME] → Use DME Formant
IME

per Resident X Residents

MCR share / Data

↓
Nat'l Avg. Res. X #
No MCR %

200-230

Average Per Resident
IME

~~\$444~~ million
244

\$ 461

Retrospective by

Indirect = IME

Additional Cost of Teaching & Non-teaching
to this part of Private
Profit margin. = Comparable
Teaching

Interim Payment:

35

FFS = Add on - POOLS - Allocation

\$ 2.2 billion



WASHINGTON HIGHLIGHTS

October 2, 1998

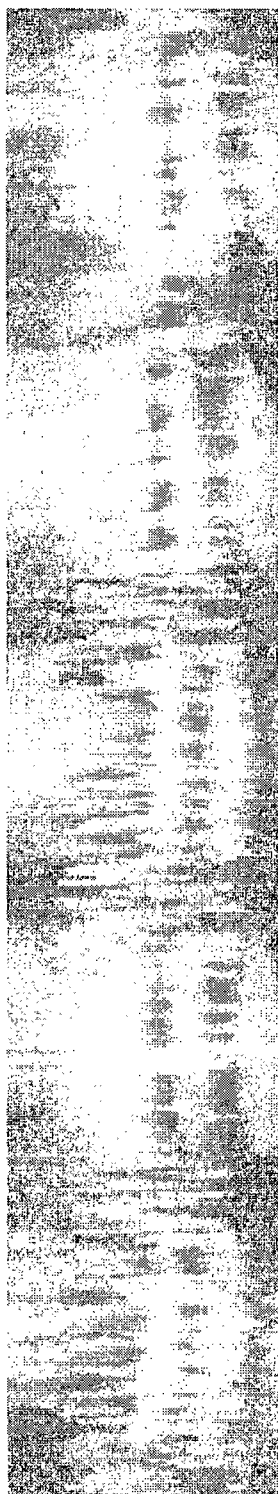
AAMC ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES
JORDAN J. COHEN, M.D. • PRESIDENT

Children's Hospitals, Nursing Educators Appear before Medicare GME Study Group

Two significant sections of the health professions training community proposed changes in the current graduate medical education (GME) system at a Sept. 29 meeting of the GME Study Group of the National Bipartisan Commission on the Future of Medicare. The National Association of Children's Hospitals (NACH) emphasized that freestanding children's hospitals, which receive minimal GME payments from Medicare, need interim federal support for their education mission until a broad-based GME financing mechanism is created. Graduate nurse educators advocated the redirection of Medicare's current payments for nurse training from hospitals with diploma programs to organizations that incur the costs of advanced clinical training for licensed registered nurses at the graduate level.

David S. Weiner, president and CEO of Children's Hospital, Boston, and a member of the AAMC's Council of Teaching Hospitals and Health Systems (COTH) Administrative Board, explained to the study group that independent children's hospitals receive limited GME support from Medicare because the program supports physician training based on hospital utilization by Medicare beneficiaries. Only children with end stage renal disease (ESRD) are enrolled in Medicare. Independent children's hospitals, numbered at about 55 institutions nationwide, must finance residency training from revenue from private payers, Medicaid payments where available, and philanthropy. This group of hospitals trains about 25 percent of all pediatric physicians. Mr. Weiner warned that the competitive market place threatens the ability of freestanding children's hospitals to remain independent. He noted that Boston Children's Hospital, like many other children's hospitals, is experiencing losses on total hospital operations, and that the direct costs of GME accounted for half of the loss.

Mr. Weiner proposed both short-term and long-term solutions. In the long-run, NACH joins with the AAMC and other groups in support of a broad-based, equitable financing system for graduate physician training. In the short-term, however, he urged Congress to establish interim commensurate GME financing for independent children's hospitals: a time-limited fund with a fixed amount of dollars paid from general revenues. Legislation



to create such a fund (S. 2049 and H.R. 3855) is co-sponsored by 23 senators, more than 75 representatives and the AAMC.

Rep. Bill Thomas (R-Calif.), administrative chair of the Bipartisan Commission, said no short-term legislative solution could be crafted by March 1999 when the commission's report is due. He noted that if Congress established a fund as an interim solution for a particular structure of "independent" hospitals, many other groups would get "in line" to ask for similar financial support and impede a comprehensive solution for GME financing. Mr. Thomas asked "why should we create hope that you can solve this problem successfully through separate legislation?" Rather than adopting a "carve-out solution for special interests," he urged independent children's hospitals to form "positive cooperative networks" with other teaching hospitals to educate Congress in the next six months about the public good nature of GME.

Linda H. Aiken, Ph.D., director of the Center for Health Services and Policy Research at the University of Pennsylvania, criticized Medicare's nursing education payment policy for being unrelated to current workforce needs. She explained that Medicare funding for nursing education has been treated with "benign neglect" because the amount of money paid for nurse training is relatively small, about \$250 million in 1994, compared to total direct GME payments of \$2.2 billion. She proposed that Medicare payments to hospitals with diploma (undergraduate) or practical or vocational nurse training programs should be redirected to advanced clinical training for licensed registered nurses at the graduate level and should be paid to organizations that incur the costs of advanced clinical training.

Senator Bill Frist (R-Tenn.), chair of the GME Study Group, noted that the commission has received comments on GME from a broad range of organizations and staff are considering all comments. The next meeting of the study group, which will address safety-net and disproportionate share issues, will occur Oct. 6 in Washington.

Information: Linda E. Fishman or Lynne L. Davis, AAMC Office of Governmental Relations, 202-828-0526.

[BACK TO TOP](#) [WASHINGTON HIGHLIGHTS HOME](#)

 ASSOCIATION OF AMERICAN MEDICAL COLLEGES	Medical Education	Research	Health Care	Student & Applicant Info	Search
	Govt. Affairs & Advocacy	News Room	Meetings & Conferences	Publications & Info Resources	About the AAMC
Home	About AAMC	Advocacy	News Room	Student & Applicant Info.	Information Resources
	Meetings	Medical Education	Research	Health Care	

Revised: 02 October 1998

hospitals receive from Medicare for their training activities.

When combined with the general reductions in payments to hospitals, the policies enacted in the BBA will require teaching hospitals to be aggressive in curbing their costs if they are to retain positive operating margins.



[\[What's New\]](#) [\[Recent Fund Work and Related Publications\]](#) [\[Programs\]](#)
[\[Fund Charts\]](#) [\[Grant Guidelines\]](#) [\[Fund Management and Financial Information\]](#)
[\[Fund History\]](#) [\[Media\]](#) [\[Other Informational Resources\]](#) [\[Fellowship Programs\]](#)
[\[Employment Opportunities\]](#)

*The Commonwealth Fund, One East 75th Street,
New York, NY 10021-2692 USA
Tel: (212) 535-0400 Fax: (212) 606-3500
World Wide Web: <http://www.cmwf.org>
E-Mail: mm@cmwf.org*