

GRADUATE MEDICAL EDUCATION FINANCING IN THE U.S.A.

Past, Present, and Future

A Report to the Committee of Interns and Residents (CIR)
Service Employees International Union

Alan Sager, Ph.D. and Deborah Socolar, M.P.H.

Directors, Health Reform Program
Boston University School of Public Health

715 Albany Street, 3TW
Boston, Massachusetts 02118

(617) 638 – 5042

asager@bu.edu dsocolar@bu.edu

www.healthreformprogram.org

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As always, we write and speak only for ourselves,
not on behalf of Boston University or any of its components.

CONTENTS

Summary	ii
Glossary of acronyms and special terms	xi
I. Introduction	1
II. Findings on GME financing	3
III. The financial context	12
IV. Proposed changes in GME financing	17
V. Relevant policy contexts	28
VI. Recommendations	36
Notes	39

SUMMARY

The CIR is concerned about funding for graduate medical education (GME) because it finances a large share of residents' salaries, of teaching and supervision, care for uninsured patients, and general support for teaching hospitals that serve vulnerable and low-income people in the nation's large cities. Recent proposals to cut or reallocate GME payments may threaten this financing.

The U.S. has some 97,989 residents in training, including approximately 33,000 in California, Florida, Massachusetts, New Jersey, and New York alone.

This report focuses on explicit GME financing by Medicare. The future of GME financing, however, rests heavily on external factors, including the financial soundness of the Medicare Trust Fund, the U.S. economy and federal budget; projected need for physicians; possible changes in the numbers of residents, their hours and specialization; the finances and roles of urban teaching hospitals; and the type of attention paid to the needs of vulnerable people and the hospitals that serve them.

Current GME financing

- Some 1,138 of the nation's 5000-odd hospitals now receive GME payments from Medicare. Total Medicare spending on graduate medical education is estimated at upwards of \$9.0 billion for 2002, with a variety of other sources financing smaller shares of GME costs.
- Medicare's payments for indirect costs of GME exceed recognized costs of teaching. Without these and without disproportionate share (DSH) payments, teaching hospitals overall in 1999 would have suffered a 0.6 percent negative Medicare margin.
- Teaching hospitals' positive margins on inpatient care Medicare patients—estimated at 10.8 percent for 1999—help sustain urban teaching hospitals as they lose money on outpatient payments from Medicare, as their margins on private payers shrink, and as states in financial crisis limit Medicaid payments.
- By the late 1990s, 16 states had instituted direct GME payments to hospitals under Medicaid, carving them out of their Medicaid payments to HMOs. Total Medicaid GME payments in 1998 totaled \$2.4 billion, about one-third of which was from New York.
- Maryland's hospital payment method uses proportionate assessments on all payers to explicitly finance GME with some \$247 million this year. In New York, some remnants persist of its former all payer GME payment system. But Massachusetts, for example, with the nation's second-highest ratio of residents to population, provides no special payments for teaching hospitals.

- Medicare pays each hospital for direct costs of medical education (DGME), using a formula reflecting Medicare's share of the hospital's patients, the number of residents, and a "hospital specific per resident amount" (PRA)—defined in law and regulation and intended to cover residents' salary, benefits, malpractice insurance, and teaching and supervision by attending physicians.
- The main concern about DGME is large differences in PRAs, which in some hospitals are triple the level used for other hospitals. Some legislative proposals would substantially narrow the range of PRAs across hospitals, in one version by freezing the higher PRAs through FY 2012. Estimates suggest that would cut payments to teaching hospitals by \$2.6 billion over ten years. Among other proposals is using one national PRA rate, perhaps adjusting for clear differences in cost of living across training sites.
- Medicare IME payments are "a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals." These costs are associated with the greater number of tests ordered by residents, the extra time that patients may spend in hospitals while residents plan and provide care, and other factors. MedPAC analysts estimate that only about half of the present IME payments cover extra costs associated with teaching. If so, the remainder of IME subsidizes teaching hospitals for other costs, which could include care provided to patients unable to pay, clinical research, and possibly inefficiencies associated with greater hospital size and complexity.
- The IME payment is a percentage add-on to each DRG payment. In FY 2003, the IME add-on is, for example, set at 5.5 percent for a hospital with 10 interns and residents per 100 beds—and rises with the resident-to-bed ratio. This add-on has declined from the 7.7 percent that prevailed through 1996, and 11.79 percent through 1985.
- A cut in FY 2003 from 6.5 percent to 5.5 percent, teaching hospitals assert, will cost them \$794 million this year, and \$4.2 billion from FY 2003 through FY 2007. All the Medicare acute hospital PPS changes in FY 2003 (excluding separate payments such as for DGME) will cut per case payments by 1.4 percent for hospitals with 100 or more residents, CMS estimates. Owing mainly to the IME cut, hospitals in large urban areas are projected to lose 0.2 percent.
- In 1997, GME provided teaching hospitals with some \$6.9 billion; this is expected to rise to over \$9.0 billion in 2002. Disproportionate share (DSH) payments to hospitals totaled \$4.5 billion in 1997, and some \$3.0 billion of this went to teaching hospitals—a sum equal to 43 percent of GME payments themselves.
- The one position that can unite all teaching hospitals is to demand more Medicare money for each hospital. But this approach may badly target scarce public dollars. The seemingly simple and fair formula may unfairly favor major teaching hospitals with higher IRBs. It is not clear that higher IRBs actually are strongly associated with greater service to patients lacking insurance, or with other measures of legitimate need.

- Profitable hospitals may not need the money, but they demand to be paid by the same formula as unprofitable hospitals, so they are not punished for being efficient. One problem with this argument is that major teaching hospitals' efficiency barely correlates with profitability, our evidence indicates.
- In data on 51 U.S. cities, for 1990, major teaching hospitals were 23.2 percent more costly, even after controlling for case mix. Among 241 major teaching hospitals, those more efficient tended to be slightly more profitable. But differences in efficiency statistically predict only about 4 percent of the differences in profitability. This is very far from a world of survival of the fittest.
- MedPAC data show that "major teaching hospitals' total profit margin averaged 2.4% compared with 4% for non-teaching hospitals in 1999...." We found a much smaller gap in 1990 in the 51 cities studied. There, 240 non-teaching hospitals' average total margin was 1.1 percent, while 241 major teaching hospitals' total margin averaged 0.9 percent—and those that were public had margins of negative 4.2 percent. By contrast, the total margin for all U.S. community hospitals in 1990 was 3.8 percent. MedPAC also found a narrowing in total margins by 1999, to 2.4 percent for major teaching hospitals and 4.0 percent for both minor teaching hospitals and non-teaching hospitals.
- Teaching hospitals vary widely in their financial status, evidence indicates. The dispersion in total margins, even after building in GME payments, in combination with the significant negative correlation between total margins and efficiency, suggests a fundamental unfairness in payments—one that GME payments have not addressed. Teaching hospital finances also vary widely over time, signaling much instability, and further indicating unfairness. Current payment methods do not reward the efficient hospitals or provide sufficient funds to those that serve many uninsured patients.
- Today's IME payments are designed to compensate teaching hospitals for their higher costs legitimately associated with training residents, for other higher costs associated with teaching, and with high costs of serving uninsured patients. IME payments are unlikely in theory to do all three, and they certainly do not in practice. We therefore urge that payments to teaching hospitals be calibrated to channel money to hospitals that most need it.
- One of our main reasons for doing so is the growing pressure on the federal budget in combination with the perception that the IME adjustment is excessive. This leads to continued cuts, and the lowest common denominator policy of the current IME add-on is an increasingly high-risk strategy. The IRB is a fair method of distributing only one-half of the money. It would be worth considering other methods of distributing the remaining one-half—perhaps in proportion to the volume or proportion of uncompensated care provided by a hospital. If this were done, it would have to be coordinated with DSH payment policy.

The Main Proposed Changes

- What aims are pursued through currently proposed changes in GME financing? To save money for Medicare by cutting perceived over-payment for GME; to make GME payments more fair across teaching hospitals, particularly by reforming and

equalizing DGME payments; to raise money for GME payments in a way that is more fair across payers—and perhaps to raise more money overall; to advance various public policy purposes affecting the number and composition of residents and future physicians; to clarify, regularize, make more fair, or otherwise reform various aspects of the administration of GME payments.

- Much of MedPAC’s work implicitly supports reducing IME adjustments below the current 5.5 percent. MedPAC’s current stance—holding IME at 5.5 percent—appears to differ from possible longer-term preferences. But lowering the rate to the “analytically justified” level of 3.1 – 3.2 percent appears likely endanger teaching hospitals and their missions unless other funding streams are raised to offset the cuts.
- COGME has stated that ideally, the IME payment formula should not reflect higher costs indirectly attributable to other teaching hospital missions, e.g. specialized services; uncompensated care, and research. Subsidies for those public goods should be directed toward the hospitals producing them through separate funding streams. COGME also better case-mix and severity measurements” and more research to set appropriate IME payment formulae. But COGME also clearly envisions off-setting increases in non-Medicare IME funding. The call for better case-mix and severity adjustments in Medicare seems unlikely to be met in the near term.
- Federal (non-Medicare) support for GME through a dedicated trust, protected from the annual budget cycle, was one recommendation of the GME Study Group of the Bipartisan Medicare Commission. It is possible that a dedicated funding stream implicitly might bolster the level of support for IME. Much would depend on the degree of political insulation provided to the dedicated trust. We doubt that political support sufficient to create such a trust will materialize soon.
- But it might well be that efforts to shift GME financing to a dedicated trust, by opening up the question of source of dollars for GME, would result instead in a decision to rely on direct annual appropriations. Financing of GME through the appropriations process appears very risky and unpredictable. In the appropriations process, GME would have to compete with other priorities. And if GME would not fare well in an appropriations process, how could it secure the even greater support that would probably be required to create a durable dedicated trust fund?
- COGME also recommends a formal all payer mechanism for financing GME. The main rationale is that all members of society benefit from having well-trained physicians and appropriately funded academic medical centers. This could be done with taxes on health insurance premiums, surcharges on teaching hospital admissions, or payroll taxes for employers that either do not offer health insurance or that provide self-insured plans. should be financed fairly. Maryland has been reasonably successful in its all payer system. Supporters of an all payer system for GME do suggest that the federal government should retain special responsibility for ensuring the adequacy of the physician supply and for teaching hospital funding. In Congress, all payer proposals in the most recent session include S. 743, introduced by Sen. Reed, and Rep. Cardin’s bill HR 2178.

- All payer financing of GME has drawn broad support within health care, including from the American Hospital Association, American Medical Association, American Association of Medical Colleges, American Medical Student Association, Pew Health Professions Commission, the Taskforce on Academic Health Centers of the Commonwealth Fund, and others. Opponents of all payer financing include MedPAC along with the HMO industry organization, the American Association of Health Plans.
- The Medicare Payment Advisory Commission and Newhouse – Wilensky generally proposed is to pay for DGME as we now pay for IME, through an add-on to each DRG payment, thereby ending the distinction between DGME and IME. MedPAC asserts that the distinctions between DGME and IME are “an accounting artifact,” not a response to the underlying realities. MedPAC notes that combining DGME and IME raises at least three questions: which dollars to consider, how to calculate the add-on, and whether to continue to subsidize teaching hospitals.
- Some propose to use one national average per resident payment for direct GME costs, which would “vary only for differences in the cost of living across geographic areas. Newhouse and Wilensky assert that differences in the PRA are not acceptable. They are a product of 1984-era differences among hospitals in the share of attendings’ efforts that was voluntary (unpaid), and also a product of differences in accounting practices.
- COGME asserts that GME payments should include incentives to advance specific goals to train more physicians of certain types. While it generally favors retaining BBA’s limits on the total number of residents in training, it accepts special exceptions aimed to redress geographic imbalances in the physician supply. MedPAC opposes efforts to use GME to advance general physician workforce goals, asserting that Medicare’s aim is to finance high-quality care for its beneficiaries, not to advance broader public policy goals.
- Some propose giving residents vouchers to cover costs of their training, whether in hospitals or community settings. This might seem appealing as a way of giving residents themselves more control, ostensibly spurring competition between residency programs. But programs already compete for residents and the resident’s ability to hold the program accountable is limited once the resident has selected a program.
- Reinhardt’s only justification for continuing GME payments is that teaching hospitals provide substantial amounts of otherwise uncompensated care. If all Americans were insured, Reinhardt would apparently be willing to end all public subsidies to physician training. He would lend doctors-in-training the funds they needed to finance their education, and then offer loan forgiveness in exchange for service in under-doctored areas.
- Cease to use the IRB ratio as the only way to distribute IME dollars: COGME favors “providing additional support for hospitals and community–based training sites that serve a disproportionate share of low-income patients. The advantage is that the money would be more closely aligned with hospitals’ actual needs for money to serve vulnerable patients. But money could be diverted to other uses. And

vulnerable patients and the hospitals that serve them are not likely to be especially popular in the 2003 Congress. This unpopularity is enhanced by the widespread belief that legitimate market forces do and should determine the fate of hospitals, not targeted public aid that only distorts the workings of this market.

The context

We identify seven elements of the context within which debates over GME take place.

The weak U.S. economy and the growing fears—and realities of a return to massive budget deficits.

The future of Medicare and particularly proposals to voucherize the program by giving each Medicare-eligible person a fixed voucher which they can use to enroll with an insurer, managed care organization, or other group. The voucher amount would be keyed to a national average, leaving high-cost teaching hospitals less likely to be used by groups that cover Medicare patients, and less likely to be paid adequately when those patients do use them.

The rising cost of U.S. health care despite the current recession, and into the future. U.S. health spending today is more than four times as much as defense spending. It is expected to double between 2001 and 2011. This will heighten pressure for cost controls. At the same time, most approaches to protect the growing number of uninsured Americans will tend to raise costs further, other things equal.

The perceived need and demand for U.S. physicians will influence public support for financing teaching hospitals. Projections of physician shortages, surpluses, and shortages succeed one another in the press. The reality is hard to discern. This uncertainty could itself undermine support for GME.

Teaching hospitals' own need and demand for physicians will be shaped by the nation's perceived needs for the doctors they train, by their internal requirements for physicians to care for patients, by the revenues and costs associated with different levels of use of residents, by decisions regarding actual ceilings on resident hours, and other forces.

The past half-century has seen profound changes in the overall configuration of urban hospitals. From 1950 to 1997, teaching hospitals' share of urban hospitals rose from 19 percent to 56 percent. The share of beds rose from 44 percent to 73 percent. Despite their high costs, teaching hospitals are often the only game in many parts of many towns. Comparing their actual costs of efficient operation with the hypothetical costs of alternatives is unwise—at least in the absence of efforts to rebalance the teaching and non-teaching shares of urban hospital care.

The U.S. might learn a good deal by examining GME financing in other wealthy nations. Too little has been done in this area, but this work lies largely outside the boundaries of the present report.

Recommendations

We offer four sets of recommendations, federal, state, local, and hospital-specific. Each recommendation should be scrutinized and assessed for its equity to hospitals in need, its efficiency in targeting funds, its political feasibility, and its administrative feasibility.

Federally, the opportunities for mischief and damage are enormous. Action should be guided by the admonition to “first, do no harm.” If this applies at retail, to care of one patient by one physician, it also applies—perhaps with even greater force—at wholesale, to massive actions that could harm millions of Americans.

We urge retention of current DGME and IME payment methods and limits until the specific financial effects of any change on the nation’s teaching hospitals are measured and analyzed, hospital-by-hospital. Blanket policies that have the effect of financially destabilizing dozens of needed hospitals (or more) must be opposed.

This applies with particular force to proposals for Medicare voucherization, which would entirely disrupt GME payments, overall Medicare payments to teaching hospitals, and therefore would harm teaching hospitals, their residents, and the vulnerable patients they serve.

Further, any Medicare voucher that was calibrated to a national average sum would inevitably harm both those patients who have no choice but to rely heavily on teaching hospitals—and those teaching hospitals themselves.

The perceived unfairness and legitimacy of today’s DGME and IME payment methods constitute risks to their financial and political survival.

The current DGME method seems blatantly unfair, particularly to hospitals with very high and very low PRAs. We suggest a five-year transition to a national average PRA, one that is adjusted for actual costs of living.

The current IME add-on of 5.5 percent is considered by MedPAC analysts to be well in excess of the 3.1 – 3.2 level that would be needed to cover costs at the average teaching hospital. This new finding is somewhat uncertain. We have seen several studies over the past decade that arrived at varying levels of legitimate add-ons. Do we have convincing reasons for believing that the new study is more accurate than its predecessors?

Still, reckless cost-cutters may not attend to the cautions that today’s IME rate of payment of 5.5 percent is essential to preserve care at many teaching hospitals. They may seize on the MedPAC study as an additional excuse to cut IME.

Protect the dollars that now flow through IME to teaching hospitals requires establishing them on a durably legitimate foundation.

Therefore, as a first intermediate step, it would be well to consider channeling more of today’s IME dollars to the DSH pool, to be distributed in accord with the DSH formula. Then, more money will go to hospitals that serve greater numbers of vulnerable patients. It might be that only a 3.1 – 3.2 percent add-on will remain in IME. Hospital-by-hospital

effects of changes in payment methods must be analyzed, with special attention given to revenue losses at needed but already-distressed hospitals.

As a second intermediate step, the financial requirements of teaching at efficiently operated teaching hospitals should be studied in greater depth and discussed publicly. This should inform better decisions about IME rates.

As a third intermediate step, DSH plus IME payments should be increasingly targeted to offset losses at needed but efficiently-operated teaching hospitals, particularly those serving high shares of vulnerable patients.

Ultimately, Medicare should join with all payers to equitably and adequately and affordably finance all needed care at all needed hospitals. That is, each needed hospital should be paid enough revenue to cover the costs of high-quality care for all patients, as long as the hospital is operated efficiently. Today's GME and DSH payments are complicated and confusing (and they probably under-pay some hospitals even while they over-pay others) because GME and DSH rest on a foundation of general payments by Medicare, Medicaid, and private payers that are themselves often unfair. As a result, it is hard to design DME and DSH payment methods that justly compensate for underlying inadequacies.

Each state government should identify the hospitals that are required to protect the health of their citizens. No state does this today, though fears of terrorist attacks are re-awakening interest in the question. So have reports of ER diversions. So have reports of bed shortages and predictions of greater shortages in the future.¹

Second, each state should identify hospitals currently facing financial distress or expected soon to face such distress. Massachusetts recently demanded quarterly financial data on hospitals in order to be better able to do this.

Third, each state should develop an operations plan and a financing plan to stabilize each needed but financially distressed hospital. This plan could include

- provisions for gubernatorial declarations of public health emergency, when necessary, to seize and take control of a needed but distressed hospital
- legislative action to enact hospital receivership statutes—laws focused on identifying and conserving needed hospitals
- special financing, such as a hospital reinsurance pool, which assesses 0.25 – 0.50 percent of each hospital's revenue annually, and uses this money to provide managerial assistance and, if needed, cash grants to distressed hospitals
- state action to build on Maryland's success with all payer hospital payment—a method of payment designed to provide each needed and efficiently-operated hospital enough money to provide high-quality care to all patients

In the end, states must act to preserve needed teaching and non-teaching hospitals, their residents, and the patients they serve. No market exists to do this. Without a market and without careful public action, we will all suffer from health services anarchy.

Local government action is essential to protect public teaching hospitals, but cities and counties can also press for support for needed non-profit teaching hospitals.

Urban public hospitals' survival depends intimately on the hospital's finances, its perceived efficiency, its perceived quality, its political support, and its physical condition. Disruption in any area can precipitate loss of the hospital. And closed is usually forever.

Building local support requires, ultimately, reinforcing the reasons for believing that the survival of the hospital is desirable and legitimate. This means enhancing patient care and improving efficiency. It means securing the best available hospital administrator, and working with unions and community groups to warn that perceptions of inefficiency, over-staffing, or low-quality care will delegitimize even badly-needed public hospitals.

Hospital-specific action can also be vital. Some hospitals drift into financial trouble. When this happens, CEOs and trustees often insist that the hospital should close because they were unable to save it. This is an act of bad faith. It is why physicians, unions, employees, and community groups at each hospital should monitor its financial performance and demand corrective action when needed. They should also insist that hospitals, their workers, and the patients they serve should not be punished because administrators or trustees failed.

Documenting the need for each hospital is vital. While state governments should take on this job, they are not likely soon to do so. Therefore, physicians, unions, employees, and community groups should do it. Identifying shortages in care and capacity that would result from a closing or downsizing is helpful, as is information on increased travel time. Further, a closing can disrupt patterns of care-giving and care-seeking. Doctors and nurses may retire or relocate, leaving them unavailable to alternative nearby hospitals. Evidence suggests that many patients may cease seeking needed care after their hospital closes.

GLOSSARY OF ACRONYMS AND SPECIAL TERMS

Abbreviations / Acronyms

AAMC	American Association of Medical Colleges, the trade association of U.S. medical schools.
ACP-ASIM	American College of Physicians – American Society of Internal Medicine
AHA	American Hospital Association, the main trade association of U.S. hospitals. Very much a lowest-common-denominator organization, one that currently favors a) more money for all hospitals and b) market-oriented solutions. AHA would therefore be likely to oppose special government efforts to protect endangered hospitals.
AMA	American Medical Association
AMSA	American Medical Student Association
BBA	Balanced Budget Act of 1997 – raised certain taxes and cut certain federal programs, including Medicare payments to doctors, to hospitals, and for GME.
CBO	Congressional Budget Office – an analytic arm of Congress, generally objective but sometimes suspected of mildly favoring the positions of the dominant party.
CIR	Committee of Interns and Residents
CMI	Case mix index – a measure of the average severity of illness of a hospital's inpatients. It is the mean of the weights assigned to each DRG. The average weight and CMI was originally 1.0, but owing to a combination of the shift of easier patients to ambulatory care and DRG creep (up-coding patients into more remunerative DRGs), the average has risen.
CMS	Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, formerly the Health Care Financing Administration (you don't want to know why they changed the name).
COGME	Council on Graduate Medical Education – Established under federal statute, and with substantial private sector and federal government representation, COGME “provides an ongoing assessment of physician workforce trends, training issues and financing policies, and recommends appropriate federal and private sector efforts on these issues. COGME advises and makes recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) and to the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Commerce.” ² Its member are drawn from medical schools, teaching hospitals, government, and other organizations. ³

COTH	Council of Teaching Hospitals, American Association of Medical Colleges “was formally established in 1965 to provide representation and services related to the special needs, concerns, and opportunities facing major teaching hospitals in the United States and Canada. The Council is the principal source of hospital and health system input into overall Association policy and direction. The approximately 400 COTH member institutions train about three-quarters of the physician residents in the United States. In addition, these hospitals provide highly specialized patient care services, and an environment in which clinical research can flourish.” ⁴
DGME	Direct graduate medical education. These payments by Medicare cover Medicare’s share of teaching hospitals’ costs of residents’ salaries and fringe benefits, their costs of paying attendings to teach and supervise residents, and their overhead costs of administering residency programs. DGME is now about one-third of total Medicare GME payments to hospitals.
DME	Direct medical education. Used interchangeably with DGME; please refer to DGME.
DRG	Diagnosis-related group – Medicare and some Medicaid programs/private payers pay hospitals for inpatient care by the discharge diagnosis, one of 490-odd categories. ICD9-CM codes are collapsed grouped into DRGs.
DSH	Disproportionate share hospital – special adjustments to Medicare payments that began in 1986. These payments are made to hospitals with high shares of low-income Medicare patients and of Medicaid patients. They aim to cover the otherwise-uncompensated higher costs of hospitals serving such patients.
FTE	Full-time equivalent (the number of FTE interns and residents at a hospital is used in calculating the IME adjustment)
FY	Fiscal year. Most hospital fiscal years and the federal fiscal year run 1 October – 30 September. Many states’ fiscal years start on 1 July. Fiscal years are identified by which January first they contain. For example, FY 2003 contains 1 January 2003.
GME	Graduate medical education (DGME + IME)
GNHYA	Greater New York Hospital Association
HCRA	The Health Care Reform Act of 1996, New York State, which ended NYPHRM.
IME	Indirect (graduate) medical education. Medicare IME payments are “a proxy to account for a number of factors which may legitimately increase

costs in teaching hospitals.”⁵ These costs are associated with the greater number of tests ordered by residents, the extra time that patients may spend in hospitals while residents plan and provide care, and other factors. IME is now about two-thirds of total Medicare GME payments to hospitals.

IRB	Intern and resident to bed ratio. The number of interns and residents divided by the number of beds in a hospital. Hospitals with higher IRBs get higher IME payments.
MedPAC	Medicare Payment Advisory Commission advises Congress on Medicare issues. It was created by BBA of 1997 by merging the former ProPAC and PhysPAC, the groups formerly responsible for monitoring Medicare's payments to hospitals and doctors, respectively. Departing from past patterns, members of MedPAC are appointed by the Comptroller General of the Government Accounting Office. The commission has seventeen members. ⁶ In 2000, Gail Wilensky was chair and Joseph Newhouse was vice-chair. Presently, Glenn Hackbarth is chair and Robert Reischauer is vice-chair.
NYPHRM	New York Prospective Hospital Reimbursement Methodology
PPS	Medicare's DRG-based Prospective Payment System. Until 1983, Medicare essentially reimbursed each hospital's costs. Since then, payment by the DRG has meant that each hospital receives a fixed payment, set in advance, for each patient admitted. The payment depends on the expected average national cost of care for a patient with that diagnosis, adjusted for regional labor and non-labor costs. Capital is also paid prospectively. Ambulatory procedures are now paid prospectively and by diagnosis as well. DME and DSH payments are distinct from these prospectively-set payments by diagnosis.
PRA	Hospital-specific per resident amount, an important element in determining a hospital's Medicare DGME payments. These PRAs are somewhat heterogeneous—probably much more than actual differences in hospital costs of DGME.
Pro PAC	Prospective Payment Assessment Commission, a predecessor to MedPAC.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. In 1983, Medicare ceased reimbursing hospital costs and substituted prospective payment by the DRG. With the end of cost reimbursement, it was necessary to pay separately for DGME and IME lest teaching hospitals be underpaid or placed at a competitive disadvantage. TEFRA formalized IME adjustments.

I. INTRODUCTION

A. Purpose of this report

The CIR is concerned about funding for graduate medical education (GME) for at least five reasons.

- It finances a large share of residents' salaries.
- It pays for a great deal of the teaching and supervision provided by attending physicians.
- It helps to pay for care of uninsured patients.
- More generally, it helps to sustain the teaching hospitals that provide great and probably growing shares of the health care received by vulnerable and low-income people who live in the nation's large cities.
- Recent proposals to cut GME payments or to reallocate them among teaching hospitals may dislocate or threaten funds that now flow to residents and hospitals.

Medicare is the main explicit or manifest source of GME funding. Owing to worries about the re-emerged federal budget deficit, the rising costs of Medicare, the high costs of training doctors, and the widely-perceived overpayment of teaching hospitals' actual GME costs, Congress and the administration can be expected to continue to scrutinize Medicare's payments for GME.

CIR's three goals are to maintain/maximize GME funding for residents' salaries, for teaching, and for care of lower income patients. CIR recognizes that current methods of payment may not be entirely reasonable, that there might be better ways to reach CIR's three goals, and that some GME proposals might undermine these goals.

CIR has commissioned this report to

- Learn more about the past and current methods of financing GME
- Review the proposed options for change, identify the stakeholders who support each option, and assess the effects of each option, if implemented
- Identify threats to CIR's goals
- Identify other possible methods of financing GME and of advancing CIR's goals.

B. Scope

This report will focus on Medicare because it is the main source of GME financing. The report will give secondary attention to Medicaid, particularly in New York State, and also to all-payer financing of GME (as one proposed option).

In the U.S. some 97,989 residents were in training in the United States. CIR now has approximately 10,000 dues-paying members in the five states of California, Florida, Massachusetts, New Jersey, and New York, or roughly 10 percent of the national total. (This rises to about 13 percent when other residents affiliated with CIR are included.)⁷ The CIR dues-paying members equal approximately 30 percent of the 33,000 residents in training in these states.⁸

C. Methods

We have proceeded by reviewing relevant published literature on GME; reports from ProPAC, PhysPAC, and MedPAC; AAMC materials; and proposals in Congress. We have reviewed web sites of COGME, the U.S. Congress, the Congressional Budget Office, the AAMC, the American Hospital Association, the Greater New York Hospital Association, the AMA, the American Medical Student Association, and the ACP-ASIM.

We also offer evidence for context from our data-set on teaching and non-teaching hospitals in 51 U.S. cities.

D. Context

Although this report focuses on explicit GME financing by Medicare, it acknowledges that the future of GME financing rests heavily on factors external to Medicare GME financing itself. Among the main external factors are:

- The financial soundness of the Medicare Trust Fund
- The condition of the U.S. economy and the size of the federal budget deficit
- The projected need for physicians
- Possible changes in the numbers of residents trained and serving in U.S. hospitals, the number of hours they work each week, and their specialization
- The financial soundness and roles of urban teaching hospitals.
 - Financial soundness influences teaching hospitals' capacity to supplement GME payments with their own funds. Similarly, since IME payments to hospitals were, from the first, designed to underwrite costs associated with teaching and with tertiary care, Medicare has never placed any restrictions on their use. IME payments are mixed with all other hospital revenues.
 - Teaching hospitals are what some economists call "multi-product" organizations. They are the main providers of last resort in cities—particularly through their emergency rooms. They deliver primary, secondary, and tertiary services to low-income and other urban residents—sometimes at no or low cost. They deliver secondary and tertiary services to suburban and rural residents. They conduct research. They train tomorrow's physicians.
 - Teaching hospitals differ in several ways. Most are non-profit; a substantial number are public; and a few are operated mainly for-profit. (The latter include Tulane and George Washington.) They differ in the closeness of their medical school affiliations and in the degree to which they rely on salaried or other medical school faculty versus attendings in private practice. They differ in the size of their financial reserves and endowments; in their market and political

power in their region; and in the strengths of their affiliations, networks, or parent corporations.

- The type of attention paid to the needs of vulnerable people and the hospitals that serve them
 - Policies shaping any dedicated federal payments for “disproportionate share hospitals” (DSH) should be considered in conjunction with any major revisions in policy on indirect medical education payments
 - Policies on state-regulated payments for hospital uncompensated care in New York, Massachusetts, and elsewhere
 - Expansion or cuts in Medicaid and other coverage for people otherwise likely to be uninsured

II. FINDINGS ON GME FINANCING

A. *Types of teaching hospitals*

Some 1,138 of the nation’s 5000-odd hospitals now receive GME payments from Medicare. According to Dobson and his colleagues,⁹ this includes:

- 119 academic health center hospitals (AHC)—these are hospitals in which “a majority of clinical chiefs of staff are also department chairs in the affiliated medical school.”
- 181 major teaching hospitals, which the AAMC defines as those with an intern and resident to bed ratio (IRB) of 0.25 or greater and 50 or more beds.
- 838 minor teaching hospitals, which the AAMC defines as those with an IRB of under 0.25 or fewer than 50 beds.

B. *Sources of GME*

1. Medicare

This table displays total Medicare spending on direct graduate medical education (DGME) and indirect medical education (IME) for 1985 through 1998, with an estimate for 2002.¹⁰

year	DGME+IME
1985	\$1.4
1990	\$4.7

1991	\$5.4
1992	\$5.9
1993	\$6.4
1994	\$6.7
1995	\$7.0
1996	\$6.8
1997	\$6.9
1998	\$7.1
2002	>\$9.0

The split between DGME and IME is not regularly reported. According to Reuter, DGME was about one-third of the 1997 total, with the rest IME.¹¹

The Medicare Payment Advisory Commission (MedPAC) estimates that teaching hospitals' 1999 overall Medicare margin (revenue less cost, divided by revenue) was 10.8 percent.¹² But without IME payments above estimated cost of teaching, and without disproportionate share (DSH) payments, teaching hospitals would have suffered a 0.6 percent overall negative Medicare margin.¹³

Positive margins on Medicare patients are helping to sustain urban teaching hospitals. These margins are particularly vital as hospitals' positive margins on private payers continue to shrink in those regions where hospitals have not gained bargaining power over payers, and as state Medicaid programs hold down hospital payments during the present crises in state finances. And DME and IME payments, in turn, play a large role in sustaining those positive Medicare margins.

2. Medicaid

According to Henderson, Medicaid paid \$2.4 billion for GME in 1998.¹⁴ Of this, roughly one-third was spent in New York State.¹⁵

Henderson warned that Medicaid's growing reliance on managed care could constrict the flow of these payments. That is because most state Medicaid programs' payments to HMOs include GME funds, but HMOs may or may not pay these dollars over to teaching hospitals. By the late 1990s, sixteen states had carved GME funds out of their Medicaid payments to HMOs, and had paid them directly to teaching hospitals.

Since roughly half of Medicaid patients are enrolled in managed care, this may seem to be a substantial threat to teaching hospitals (By contrast, only about one Medicare patient in seven was enrolled in managed care in the late 1990s.) But it is likely that the share of Medicaid-financed hospitalizations accounted for by Medicaid managed care enrollees was considerably smaller than one-half. That is because parents and young children were disproportionately enrolled in HMOs under state Medicaid waivers. Older and disabled patients, who use hospital care at much greater rates, were much less likely to be enrolled in managed care.

3. All payers/Private payers—Maryland and New York State

Maryland's all payer hospital payment method continues to explicitly finance GME through proportionate assessments on all payers. In hospital rate year 2002, DGME payments for 1,557 residents were \$78.6 million and IME payments were \$168 million, for a total of \$246,600,000. Payments therefore equaled some \$158,000 per resident. Concerned by the rising number of residents, Maryland moved in 2002 to toughen its process for approving new resident positions at teaching hospitals.¹⁶

New York State abandoned its own all payer hospital payment method, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), in 1996. Before it was ended, NYPHRM channeled some \$2.8 billion in GME payments to teaching hospitals annually. Of this, some \$1.0 billion was from Medicare, and \$1.8 billion was Medicaid and private funds. With almost 15,000 residents, the GME (DGME plus IME) cost per resident was about \$188,000 annually.

The Health Care Reform Act (HCRA) of 1996, which ended NYPHRM, provided for considerable continuity in GME funding. This is not surprising since New York State, with 6.7 percent of the nation's population,¹⁷ trains between 15 and 19 percent of the nation's residents.¹⁸ (By contrast, Massachusetts, with the nation's second-highest ratio of residents to population, dismantled its own all-payer payment mechanism partially in 1985 and completely in 1988 without providing any special payments for GME specifically or teaching hospitals generally.)

Medicaid and other state programs, such as workers compensation, continued to pay some \$840 million for New York GME annually. Private payers pay some \$500 million annually. They continue to finance DME at the same rate they previously paid under NYPHRM. They finance IME at more than one-half the rate they previously paid. These dollars are raised under state law through a per member per month assessment on individuals covered by each payer.¹⁹

New York State has sought to use its GME payments to effect changes in the types and numbers of residents—more in primary care, greater minority participation, and fewer residents overall.

4. Other

A variety of other sources finance smaller shares of GME costs. In recent years, the U.S. Department of Veterans Affairs has funded about 8,900 of all residency positions, while the Department of Defense funds about 3,000 positions. Other sources include new GME funding for Children's hospitals, and Title VII grants for training primary care providers and caregivers for underserved areas.²⁰

C. Medicare Direct Graduate Medical Education (DGME) financing methods today, dollars, sources, and recipients

1. Calculating Direct Graduate Medical Education (DGME) payments

These payments by Medicare cover Medicare's share of teaching hospitals' costs of residents' salaries and fringe benefits, their costs of paying attendings to teach and supervise residents, and their overhead costs of administering residency programs.

Under cost reimbursement, hospitals simply billed Medicare for these costs. But once Congress began applying limits on hospitals' costs, it became necessary to calculate and pay for direct medical education costs separately, lest teaching hospitals be unfairly pinched by limits on overall Medicare payments. These limits were first embodied in legislation in 1972 (P.L. 92-603), and were applied with increasing force in the late-1970s. Cost reimbursement for costs of ordinary hospital care was ended by the passage of Medicare's prospective payment legislation to pay hospitals by DRGs starting in 1983. That is when DGME payments were formalized.

Medicare pays each hospital for the direct costs of medical education according to a conceptually simple formula.

- First, count the number of eligible residents. This can include residents working outside the hospital—in a physician group or HMO, for example—as long as the hospital has a written agreement with the site that requires the hospital to continue to pay the resident's salary while working at the separate site.²¹ Residents are fully counted during their initial residency period, but are counted only at one-half during a subsequent residency for further specialty or subspecialty training.
- Second, multiply this number by the "hospital specific per resident amount" (PRA), a sum defined in law and regulation. This sum is designed to cover costs of the resident's salary, fringe benefits, malpractice insurance, teaching, and supervision.
- Third, multiply this product by Medicare's share of the hospital's patients, measured by its percentage of the hospital's inpatient days.

For example, if a hospital has 200 residents, a PRA of \$60,000, and a Medicare share of inpatient days of 50 percent, it would receive \$6,000,000 in DGME payments annually from Medicare.

According to Biles, "The average direct cost of graduate training in teaching hospitals was \$54,000 per resident in 1993."²²

Newhouse and Wilensky note that current DGME PRAs reflect 1984 "costs per resident, trended forward by the change in the Consumer Price Index. Reimbursement has been held at 1984 costs plus inflation to preclude hospitals from simply moving other costs to those that are now passed through."²³

2. Is the difference in PRAs across hospital appropriate?

It seems reasonably clear that the main DGME issue concerns the inter-hospital differences in the PRA. Reuter notes that DGME payments vary very substantially across hospitals. At the extremes, 65 of the 1,100 teaching hospitals' PRAs exceeded \$100,000 per year but 275 have PRAs below \$38,000.²⁴

In response to PRAs' considerable variation, some legislative proposals would cap increases in the maximum PRA and others would raise the minimum PRA. Together, these changes would substantially narrow the range from low PRA to high PRA across hospitals.

The PRAs that are above 140 percent of a geographically-adjusted national average PRA were frozen legislatively in FY 2001 and FY 2002. This cap is now scheduled to rise by a market basket inflation rate plus 2 percent for FY 2003 through 2005. Some proposals would freeze PRAs in excess of 140 percent at their current rates through FY 2012.²⁵ AAMC reports certain estimates that this freeze would cut payments to teaching hospitals by "\$600 million in five years and by \$2.6 billion over ten years."²⁶

Other legislative proposals would gradually raise the minimum PRA up to 100 percent of the locality adjusted national average.

Other proposals urge one national PRA rate, perhaps acknowledging clear differences in cost of living across training sites.

If Medicare pays only for its proportionate share of DGME, the reader might wonder, who pays for the remainder? The answer is, other payers. The mechanisms by which this happens are rarely as visible as those of Medicare. Few other payers manifestly allocate dollars for DGME. As noted earlier,

- New York State does so through its Medicaid program and its treatment of uncompensated care.
- Maryland, with its all-payer rate regulation, can be considered to govern payment for DGME (and IME) because it explicitly recognizes teaching hospitals' higher costs.

Medicare explicitly targets dollars to support its fair share of DGME. A few other payors in a few states do the same. To finance the remaining costs of DGME, hospitals find the money to pay and supervise residents in their general revenues—the sums they are paid by HMOs, Blue Cross, commercial insurers, and other payers. This money is fungible—it can be spent as hospitals wish. In greater Boston, for example, we have been informed that several large teaching hospitals are paid as much as twice as are non-teaching community hospitals for very similar-seeming services (cases).²⁷

D. Medicare Indirect Medical Education (IME) financing methods today, dollars, sources, and recipients

Medicare IME payments are "a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals."²⁸

These costs are associated with the greater number of tests ordered by residents, the extra time that patients may spend in hospitals while residents plan and provide care, and other factors.

MedPAC analysts have concluded that only about half of the present IME payments actually are needed to cover extra costs associated with teaching. If this is so, then the

remainder of IME constitutes a subsidy to teaching hospitals that addresses costs other than those associated with teaching. Those costs could include care provided to patients who are not able to pay, costs associated with clinical research, and possibly the inefficiencies associated with greater hospital size and complexity.

1. The formula for calculating IME

The IME payment is added to each Medicare payment for each patient discharged from an acute care hospital. Because Medicare pays each hospital a particular amount for each discharge, the IME payment is a percentage add-on to each DRG payment.

Currently, in FY 2003, for example, the IME add-on is set at 5.5 percent for a hospital with 10 interns and residents per 100 beds—called an IRB ratio of 0.1. All residents are fully counted for IME, whether they are in their initial residency period or are completing a second residency.

- Example: This means that a teaching hospital with 300 beds and 30 residents would receive an additional payment equal to roughly 5.5 percent of each basic DRG payment.

Hospitals would receive an additional payment for each 0.1 increment in the resident-to-bed ratio. So for a hospital with 150 beds and 30 residents—a ratio of 0.2 (or 20 percent) — the total IME add-on would double, to 11.0 percent of each basic DRG payment. This can also be described as rising from a ratio of 10 percent to 20 percent, a 10 percentage point rise (often referred to as a “10 percent rise”) in the IRB.

In practice, this is not the exact add-on, owing in part to complexities in the way in which residents and beds are counted, and in part to the nature of the formula by which the IME is calculated.

The Congressional Budget Office provides the formula that was in effect from 1 October 1988 to 1 October 1997, when the add-on was 7.7 percent for each 10 percentage point rise in the IRB:²⁹

$$\text{IME} = \text{DRG payment} * 1.89 \{ [1 + (\text{FTE residents}/\text{number of beds})]^{0.45} - 1 \}$$

Since 1 October 2002, the multiplier has been 1.35, rather than 1.89 (having dropped in a series of cuts over the years), thus generating the add-on of 5.5 percent noted above.

A host of forces influence the nature and adequacy of Medicare’s payment for IME. The discussion of the evolution of these payments over the past 30 years makes this clear. Throughout this period, efforts to slow the growth in Medicare Part A hospital costs have contended with desires to protect teaching hospitals, the care they give, and the residents they train.

2. The evolution of IME payments since Medicare's inception

The following section relies heavily on a summary provided by the American Association of Medical Colleges (AAMC),³⁰ on reports from COGME, ProPAC, PhysPAC, MedPAC, and other sources.

When Medicare reimbursed each hospital's costs, it did not need to explicitly or separately recognize the direct or indirect costs of medical education. Those costs were simply included among the ordinary costs reimbursable by Medicare—costs that included nurses' salaries, IV solution, prescription drugs, or the electric bill.

When Medicare gradually moved away from unrestricted cost reimbursement in 1972, it recognized that teaching hospitals were more expensive than ordinary community hospitals, even after deducting the direct costs of medical education. (This was not to say that any particular share of teaching hospitals' greater expense was legitimate or appropriate, only that it was present.)

It was found that teaching hospitals with more interns and residents per bed were more costly, other things equal. Therefore, in 1980, Medicare's ceilings on payments to hospitals were raised for teaching hospitals in proportion to their IRBs. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) formalized this adjustment for teaching costs in proportion to each teaching hospital's IRB.

The degree of formalization became greater when Medicare began paying hospitals by diagnosis-related groups (DRGs) in 1983.

The following information tracks the ups and downs in the size of the IME add-ons:

- A December 1982 report from the Secretary of the Department of Health and Human Services (DHHS) estimated that Medicare's cost per discharge rose about 5.69 percent with each ten percent rise in the number of residents per hospital bed.³¹ It is important to note that this is a statistical correlation, not a causal relation. The calculated relationship is derived from a multiple regression analysis. That is, the 5.69 percent rise is statistically controlled for case mix index, number of beds in the hospital, local wages, and city size.
- But the Congressional Budget Office (CBO) estimated that this 5.69 percent add-on would financially harm 71 percent of teaching hospitals (by reducing their income below levels prevailing under cost reimbursement). The Reagan administration therefore proposed doubling the IME add-on to "11.79 percent for each 10 percent increase in the IRB."³²
- The 11.79 percent add-on was lowered to 8.7 percent in 1986. At the same time, 0.6 percentage points of this add-on was carved out to finance the new disproportionate share (DSH) adjustment, leaving a net IME add-on of 8.1 percent.
- In 1987, the IME add-on was lowered to 7.7 percent by the Omnibus Budget Reconciliation Act of 1987.

- In 1997, the Balanced Budget Act (BBA) lowered the add-on to 7.0 percent. Further substantial cuts were scheduled by BBA through 2003. These scheduled cuts were substantially tempered and delayed by legislation enacted in 1999 and 2000.
- As a result of all this, the IME add-on was 6.5 percent in federal fiscal years (FY) 1999 through FY 2002.³³
- On 1 October 2002, the IME was cut to 5.5 percent for FY 2003 and subsequently.³⁴

This amounts to five cuts in IME over sixteen years. Some might conclude that IME has been cut so much that further cuts are unlikely. Others might conclude that cutting IME appears to some in Congress to be a soft target, making further cuts likely.

Teaching hospitals assert that this latest cut will cost them \$794 million in IME payments in FY 2003, and \$4.2 billion from FY 2003 through FY 2007.³⁵

The federal Centers for Medicare and Medicaid Services (CMS) projects that “the impact of this change [will] be a 0.9 percent reduction in hospitals’ overall FY 2003 payments. The impact upon teaching hospitals would be greater.”³⁶ All the Medicare acute hospital PPS changes in FY 2003 (this excludes separate payments such as those for DGME) will reduce per case payments by 1.4 percent for hospitals with 100 or more residents, CMS estimates. CMS also projects a rise in per case payments to non-teaching hospitals by 1.3 percent. Owing largely to the IME cut, hospitals in large urban areas are projected to lose 0.2 percent.³⁷

Another change is noteworthy. As a rising share of Medicare patients enrolled in HMOs—14 percent in 1997 and expected to double by 2003³⁸—teaching hospitals worried that HMOs would not pay teaching hospitals for their DGME and IME costs. The 1997 BBA addressed this concern by carving out GME costs from Medicare capitation payments to HMOs and directing those payments directly to teaching hospitals that serve Medicare managed care patients.

(Note, however, that, as AARP put it, “The BBA did not address the more general concern about the impact on teaching hospitals of low utilization of teaching hospitals by managed care plans.”³⁹)

The 1997 BBA was expected to cut IME by \$5.6 billion over five years, and it was also expected to cut \$2.2 billion more by eliminating disproportionate share (DSH) and IME payments on outlier cases, for a gross loss of \$7.8 billion. But carving out the GME costs from payments to HMOs was expected to add back some \$4.0 billion in payments to teaching hospitals over five years.⁴⁰ The net loss was therefore expected to be \$3.8 billion over five years (\$7.8 billion less 4.0 billion).

The threatened loss of GME payments from Medicare HMOs has receded as HMOs’ shares of Medicare enrollees have dropped in recent years. (The HMO industry, though, still calls for the carved out payments to be restored, complaining that HMOs have been unable to offset their loss by negotiating lower prices with hospitals.⁴¹ Another view is that such price reductions would be unwarranted for any HMOs that had failed to pass GME dollars on to hospitals.) This suggests that some dangers may seem very serious or even alarming at one time, but can turn out to be less so. At the same time, unforeseen dangers can emerge.

E. Medicare Disproportionate Share (DSH) payments

Medicare DSH payments are not aimed to subsidize teaching or related costs. But teaching hospitals garnered fully \$3 billion in DSH payments in 1997, or roughly two-thirds of DSH payments in that year. Given the heavy overlap in hospitals receiving GME and DSH funds, and the overlap in aims of IME and DSH payments, it is essential to discuss DSH in this report. This section relies very heavily on an AAMC report on the subject.⁴²

1. Aim

DSH was originally intended to compensate hospitals for the higher costs thought to be associated with serving lower income Medicare patients. But a 1990 CBO analysis of 1987 Medicare data seemed to indicate that higher hospital costs associated with serving a greater share of low-income Medicare patients had disappeared. AAMC considers that Congress and CBO see a second and perhaps more important aim—to “preserve access to care for Medicare and low-income populations by financially assisting the hospitals they use.”⁴³ This generally also means aiding hospitals that serve higher shares of uninsured patients.

DSH was created by Congress in 1986, after several years of Reagan administration delays in implementing Congressional instructions to identify DSH hospitals. Original financing came entirely from carving out 0.6 percentage points from the IME add-on and from lowering the base DRG payment for Medicare inpatient services. One justification offered for using IME dollars for DSH was that much of the money would go to the same group of hospitals, but in better proportion to service to service to lower income people. In 1990, DSH was made permanent.

2. Dollars and who gets them

In 1997, DSH payments totaled \$4.5 billion—or 6 percent of total PPS payments to hospitals—up from \$1.1 billion in 1989. The increase was attributable in part to specific Congressional appropriations for various groups of hospitals over the years.

About 40 percent of U.S. hospitals were eligible for DSH in 1997. Fully 95 percent of the dollars go to urban hospitals and 250 hospitals garner one-half of the money.

The BBA of 1997 cut DSH by 5 percentage points over FY 1998 through 2002.

3. Payment calculation

DSH payments depend essentially on the share of a hospital’s inpatient days that are devoted to serving Medicaid patients plus those Medicare patients who receive supplementary security income (SSI), federal payments to certain aged or disabled lower-income people. These two proportions are summed to the DSH percentage.

Hospitals must meet a minimum DSH percentage to qualify for aid. After the DSH percentage rises above a certain level, the generosity of the payments increases. This means that hospitals that serve more DSH patients receive disproportionately more DSH money, thereby helping to account for the concentration of DSH funds in 250 hospitals.

Ten separate formulas are used to distribute DSH payments.

III. THE FINANCIAL CONTEXT

A. Higher IME payments across-the-board—the lowest common denominator

Teaching hospitals vary enormously in their profitability, their efficiency, and other factors, as the data presented in this section show.

When confronting the Medicare program, the one position that can unite all teaching hospitals is to demand more money for each hospital. Raising or maintaining the size of the IME add-on has been teaching hospitals' main concrete pursuit. It can be thought of as a lowest common denominator.

This is appealing for at least three reasons. First, it is simple. "We teaching hospitals have higher costs, and here is the add-on that generates Medicare dollars to help cover those costs."

Second, it unites all teaching hospitals. Efforts are not dissipated by fights among teaching hospitals to redistribute IME dollars, to channel money to hospitals serving more uninsured patients, for example.

Third, the across-the-board add-on for IME appeals to those who imagine that teaching hospitals are competing equally in a free market, that some are doing better than others, but any public assistance should be across-the-board. The IME add-on appears to be equitable across-the-board. It does not differentiate money-making from money losing hospitals, and it certainly does not inquire into the reasons why some hospitals make or lose money. It looks like a fair formula. Government does not seem to differentiate by intervening to pick winners or lift up losers. All the family's children are treated equally.

Even though this approach is appealing, it may badly target scarce public dollars. First, hospitals with more residents may be rewarded excessively while hospitals with fewer residents may be rewarded inadequately. In other words, the seemingly simple and fair formula may unfairly favor major teaching hospitals with higher IRBs. Second, the IME add-on assumes that higher IRBs are strongly associated with greater service to patients lacking insurance, or with other measures of legitimate need. It is not clear that this has been demonstrated. The current work at MedPAC, suggesting that a 3.2 percent IME add-on would cover extra costs associated with teaching, is itself an average across all teaching hospitals. It does not begin to differentiate by any factor other than IRB.

B. Financial characteristics of teaching hospitals

1. Teaching hospitals vary enormously in their profitability and in their efficiency

As just noted, the lowest common denominator for teaching hospitals is to demand more generous payment methods for all teaching hospitals, rich or poor, public or non-profit. (This is not only true of teaching hospitals—it applies equally to hospitals in a given state, or in the entire nation.⁴⁴) Profitable hospitals may not need the money, but they demand to be paid by the same formula as unprofitable hospitals. Otherwise, they sometimes argue, they would be punished for being efficient. One problem with this argument is that major teaching hospitals' efficiency barely correlates with profitability.

2. Efficiency of teaching and non-teaching hospitals

We analyzed the efficiency of hospitals in the 51 cities on which we have data.

<u>Type of hospital</u>	<u>Mean case-mix adjusted cost per adjusted admission, 1990</u>	<u>Number of hospitals</u>
Non-teaching hospital	\$4,402	240
Minor teaching hospital	\$4,808	77
Major teaching hospital	\$5,424	241
All hospitals	\$4,900	558

Major teaching hospitals were 23.2 percent more costly, even after controlling for case mix. Case mix was calculated using Medicare case weights. Medicare case mix indices tend to correlate very closely with all-patient case mix indices.

Efficiency was defined as total expenses per adjusted admission in 1990, divided by Medicare case mix index in 1990. Adjusted admissions are a blend of inpatient and outpatient care, where outpatient department and ER visits are accumulated into admission-equivalents in proportion to their charges (gross revenues).

3. Teaching hospitals' profitability mildly correlates only mildly with their efficiency

In a reasonable world of competition by price and quality, most people would expect that the more efficient hospitals would be substantially more profitable. This has never been true in the real world of urban hospitals.

We looked, for example, at 240 major teaching hospitals open in 1990 and examined the association between their efficiency (case mix-adjusted cost per adjusted discharge—adjusted discharges reflect outpatient as well as inpatient volume) and their total financial margins (the difference between total revenue less total expenses, divided by total revenue).

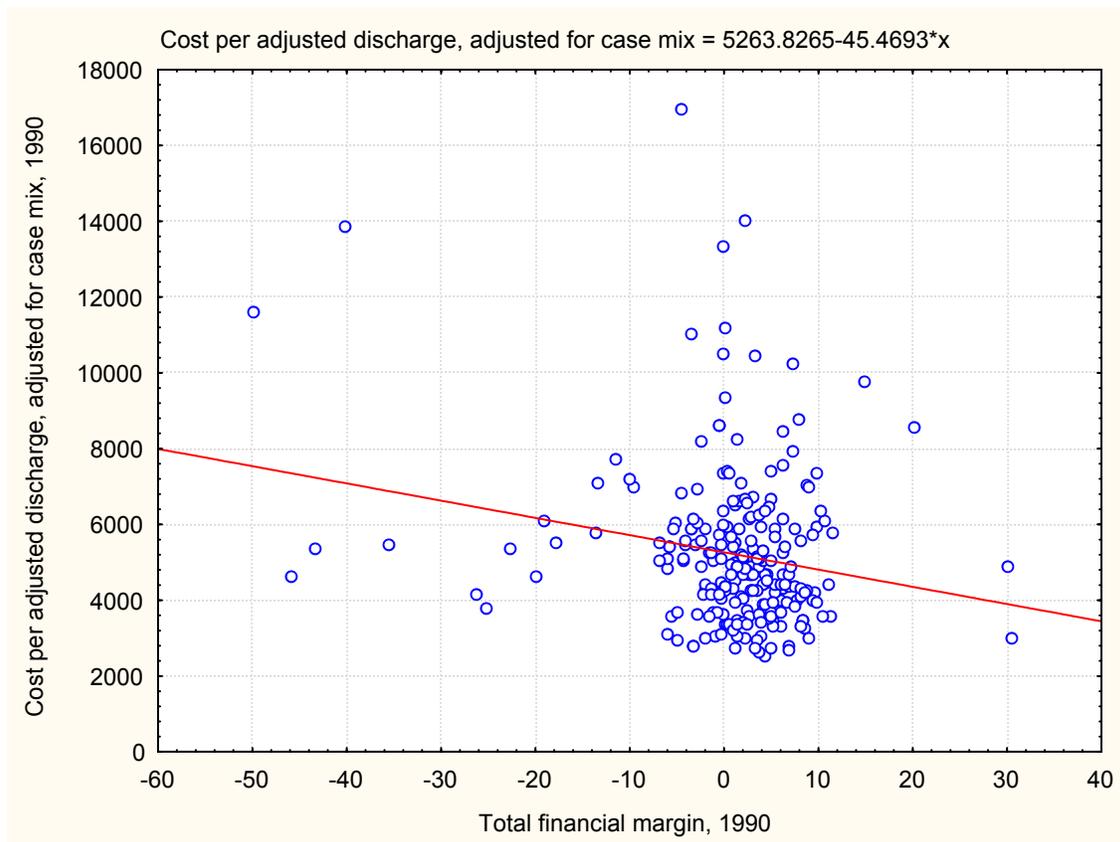
Please note: In our studies of hospitals in 51 cities, "major teaching hospitals" are those designated in the *Graduate Medical Education Directory* (Green Book) as such. These are generally hospitals that train substantial numbers of medical students and residents. This different from the COGME standard of 25 or more residents per 100 beds. In this analysis, one extreme cost outlier was deleted.

The average total margin in 1990 was 0.96 percent and the average case mix-adjusted cost per adjusted discharge in 1990 was \$5,220.

Major teaching hospitals' efficiency was slightly correlated with their profitability, at $R_p = -0.20$, $R^2 = 0.04$, significant at 0.002.⁴⁵ That is, lower-cost, more efficient hospitals tended to be slightly more profitable. But this was a very mild correlation, meaning that differences in efficiency statistically predict only about 4 percent of the differences in profitability. This is very far from a world of survival of the fittest. The data are graphed in the following exhibit.

Exhibit

Scatterplot of financial status correlated with hospital efficiency



We have studied the survival of urban hospitals over the years from 1936 to 1997. Examining hospitals decade by decade, there has never been a time when efficient hospitals have been more likely to survive. This has been true both in simple comparisons of the efficiency of closed hospitals and surviving hospitals, and also in a host of multi-variate analyses.

4. Financial status of teaching and non-teaching hospitals

Hensley reports federal MedPAC data showing that “major teaching hospitals’ total profit margin averaged 2.4% compared with 4% for non-teaching hospitals in 1999....”⁴⁶

We found a much smaller gap in 1990 in the 51 cities studied. There, 240 non-teaching hospitals’ average total margin was 1.1 percent, while 241 major teaching hospitals’ total margin averaged 0.9 percent. Even after bringing in the 77 more profitable minor teaching hospitals (whose total margins averaged 2.8 percent), the average total margin in the 51 cities was only 1.3 percent.

Table

Financial Status of Teaching and Non-teaching Hospitals, 2000

Type of hospital	Total margin in 2000	Number of hospitals
Major teaching hospital	0.9%	240
Minor teaching hospital	2.8%	77
Non-teaching hospital	1.1%	241
All hospitals	1.3%	558

By contrast, the total margin for all U.S. community hospitals in 1990 was 3.8 percent, almost three times as great as that prevailing in the 51 cities, according to data reported to the American Hospital Association.⁴⁷

MedPAC reports a total margin of 3.6 percent nationally.⁴⁸ MedPAC also reports a wider gap in 1990 between major teaching hospitals and other hospitals nationally than we found in our 51-city study—1.1 percent total margins for major teaching hospitals, 4.6 percent for minor teaching hospitals, and 4.3 percent for non-teaching hospitals.⁴⁹

This is partly attributable to the different hospitals examined and partly to MedPAC’s different classification of major teaching hospitals as those with 25 or more residents per 100 beds (while we use the Green Book’s classification).

MedPAC also found a narrowing in total margins by 1999—to 2.4 percent for major teaching hospitals and 4.0 percent for both minor teaching hospitals and non-teaching hospitals.⁵⁰

Please note; Used in this sense, community hospitals are all non-federal acute general hospitals. (In this report, we will not refer to non-teaching hospitals as community hospitals. For simplicity, we will refer to them as non-teaching hospitals.)

5. Financial status of major teaching hospitals by ownership

We examined 1990 total margins of the 234 major teaching hospitals in 51 cities studied. Not surprisingly, the 46 public major teaching hospitals averaged a total margin of negative 4.2 percent. The 188 non-profit major teaching hospitals' total margins averaged positive 2.1 percent.

6. Differences in the financial status of teaching hospitals

Teaching hospitals vary widely in their financial status. In 1990, for example, 241 major teaching hospitals in the 51 cities studied had an average total margin of 0.9 percent. But the standard deviation in total margin was fully 9.8, leaving a coefficient of variation of fully 7.5. This relative standard deviation—the standard deviation divided by the mean—is very large indeed. As shown in the following table, non-teaching hospitals' relative standard deviation was almost as high. Minor teaching hospitals' total margins were much more homogeneous.

These underlying differences in total margins are not mere statistical artifacts. The dispersion in total margins, even after building in GME payments, in combination with the significant negative correlation between total margins and efficiency, suggests a fundamental unfairness in payments—one that GME payments have not addressed.

Table

Dispersal of Urban Hospital Total Margins, 1990

<u>Type of hospital</u>	<u>Mean total margin</u>	<u>Number of hospitals</u>	<u>Standard deviation in total margin</u>	<u>Coefficient of variation (Mean/S.D.)</u>
Non-teaching	1.1%	240	10.7	9.3
Minor teaching	2.8%	77	7.3	2.6
Major teaching	0.9%	241	9.2	9.8
All hospitals	1.3%	558	9.6	7.5

7. Instability of teaching hospitals' finances

Teaching hospitals' finances vary over time. The correlation between the financial margins of teaching hospitals in the 51 cities in 1980 and 1990, for example, was slightly positive, but only at $R_p = .14$; $R^2 = .02$. This signals very considerable instability. A hospital's financial margin in 1980 was not a particularly good predictor of its finances in 1990. That is, hospitals in good condition in 1980 could not particularly expect to be in good condition in 1990.

We conclude, in light of this evidence, that current methods of paying teaching hospitals in the 51 large and mid-size cities studied are simply unfair. They do not reward the efficient hospitals or punish the inefficient hospitals. They do not provide sufficient

additional funds to those hospitals—particularly public hospitals—that serve large numbers of uninsured patients.

Today's IME payments are designed to compensate teaching hospitals for their higher costs legitimately associated with training residents, for other higher costs associated with teaching, and with high costs of serving uninsured patients.

IME uses one bullet—the IME add-on—to try to hit these three targets. IME payments are unlikely in theory to hit all three targets. And they certainly do not hit all three in practice. We therefore urge that payments to teaching hospitals be calibrated to channel money to hospitals that most need it.

One of our main reasons for doing so is the growing pressure on the federal budget in combination with the perception that the IME adjustment is excessive. The perception of excess in this climate leads to continued cuts. Clinging to the lowest common denominator policy of the current IME add-on therefore becomes an increasingly high-risk strategy.

Since only about one-half of IME actually paid for costs associated with resident training (when the IME was at an IRB of 6.5 percent per 10 residents per 100 beds),⁵¹ the IRB is a fair method of distributing only one-half of the money. It would be worth considering other methods of distributing the remaining one-half—perhaps in proportion to the volume or proportion of uncompensated care provided by a hospital. If this were done, it would have to be coordinated with DSH payment policy.

Saving today's IME dollars and making them available to channel to urban hospitals that badly need this money requires abandoning the lowest common denominator policy. It requires retaining fair IME payments that cover actual teaching-related costs. And it requires assessing the financial needs of efficiently operated urban hospitals and ensuring that funds adequate to meet those needs are provided.

Against this background, we review the range of proposals to reform or otherwise change GME payments.

IV. PROPOSED CHANGES IN GME FINANCING

A. What aims are pursued through currently proposed changes in GME financing?

1. One main aim is to save money for Medicare by cutting perceived over-payment for GME. This might be accomplished, for example, by ceasing to pay GME from the Medicare trust fund and instead appropriating it annually from federal general revenues. This would place GME in direct annual competition with other claims on federal dollars.

This change would be a matter of degree, not a matter of kind. GME already competes to some extent with other claims. The AARP, for example, has recently resisted a

variety of demands for restoring cuts in Medicare payments to hospitals and doctors until a Medicare prescription drug benefit is enacted.⁵²

2. A second aim is to make GME payments more fair across teaching hospitals, particularly by reforming and equalizing DGME payments.

3. A third aim is to raise money for GME payments in a way that is more fair across payers—and perhaps to raise more money overall.

4. A fourth aim is to advance various public policy purposes affecting the number and composition of residents and future physicians. These include efforts to cut the number of residents, to raise the share trained in primary care, to reduce resident hours, and to increase the minority or rural-born share of residents.

5. A fifth aim is to clarify, regularize, make more fair, or otherwise reform various aspects of the administration of GME payments. These include provisions relating to which residents to count, how to allow for movement of residents from closed hospitals without penalizing hospitals to which they transfer, and the like.

For example, CMS is considering using 35 percent as a minimum occupancy rate in IME and DSH calculations. If a hospital's reported occupancy is below 35 percent, its bed count would be reduced to the number yielding a 35 percent occupancy rate. This would tend to raise some IME payments but to lower DSH payments. CMS reportedly believes that some hospitals, especially smaller urban hospitals, may have kept unneeded beds because they would draw higher DSH payments.⁵³

B. The main proposed changes—and how much support have they attracted

The main widely-discussed proposed changes are

- to further reduce the IME adjustment (MedPAC)
- to create a dedicated trust fund for GME or to rely on annual appropriations
- to establish all payer GME financing method (endorsed by COGME)
- to moderately reform GME payment methods
- to narrow or eliminate the disparities in the DGME PRA
- to use GME payments to advance larger public goals, such as changes in the configuration of the physician workforce—numbers, degree of specialization, minority representation, and the like

Proposed changes that have not received as much visibility are

- to give residents vouchers for GME, which they could use to train where they wish, in or outside hospitals.

- to end federal GME financing⁵⁴
- to cease to use the IRB ratio as the exclusive method of distributing IME dollars.

1. Reduce IME adjustments below the current 5.5 percent

Much of MedPAC's work implicitly supports this recommendation.

Newhouse and Wilensky assert that hospitals do not bear the costs of training residents. Rather, residents do. If this is so, why are teaching hospitals more costly? Because residents' presence means a different, lengthier, or costlier pattern of treatment; because of the costs of research in teaching hospitals; because of unmeasured case mix differences; and because teaching hospitals may be less efficient (though Newhouse and Wilensky do not credit the last).

"Residents are willing to accept lower wages because the skills they acquire while providing care allows [sic] them to earn more in the future or achieve greater job satisfaction."⁵⁵

Raising payments to teaching hospitals in proportion to their IRB constituted an unintended incentive to teaching hospitals to add still more residents.

According to Hensley, MedPAC:

says that the indirect education payment rate is more than twice the cost that can be attributed to the expenses of teaching and more complex cases treated at academic medical centers.

'Gradually, we should reduce the payments to the point that they pay for the full, added burden [for teaching hospitals] associated with providing care to Medicare patients,' says Robert Reischauer, president of the Urban Institute and vice chairman of MedPAC.

Financing other health initiatives of academic medical centers is all well and good, he says, but 'if we want to pay for them, then let's be up front about it' and not lump them together with compensation for education.⁵⁶

Hensley notes further that the recent cut in IME to 5.5 percent has not been devastating. " 'We've been asking academic medical centers what the likely impact will be to them, and most of them have told us that it's going to be modest at worst,' says Bruce Gordon, senior vice president for the health-care bond ratings group at Moody's Investors Service, New York."⁵⁷

Hensley's final assertion is that "if teaching hospitals need more money for health-care programs besides education, they should ask for it. Just like everyone else does." This is the view that constitutes the single greatest threat to continuation of IME payments in excess of actual teaching costs—a level that one MedPAC analysis estimates at about 3.2 percent.⁵⁸

Strikingly, Recommendation 2 in COGME's December 2000 report is that "IME payments should be set at no more than the analytically justified level for teaching activities." COGME here cites a MedPAC estimate that that would mean a 3.1 percent—rather than 5.5 percent—adjustment, and suggests that "the difference could be targeted toward achieving specific workforce and educational goals...or toward supporting uncompensated care."⁵⁹ The report continues:

Ideally, the IME payment formula should not reflect higher costs indirectly attributable to other teach hospital missions, e.g. specialized services; uncompensated care, and research. Subsidies for those public goods should be directed toward the hospitals producing them through separate funding streams....

COGME also calls for "refinements in the prospective payment system to incorporate better case-mix and severity measurements" – states that "research is needed to determine the appropriate IME payment formulae."

AAMC asserts, on several related matters,⁶⁰ that COGME's recommendations appear confusing, even contradictory. AAMC says that it is not always clear which pools of funding COGME is focusing on. While implying that current IME payments should be reduced so as not to "subsidize inefficient providers and give teaching hospitals a competitive edge," COGME also clearly envisions off-setting increases in non-Medicare IME funding. The call for better case-mix and severity adjustments in Medicare seems unlikely to be met in the near term. And if substantial research is still needed, as recommended, is it wise to push now for a cut in the IME adjustment to "the analytically justified level"?

Further, despite apparent support for a rise in funding for uncompensated care, COGME's accompanying Recommendation 8 is brief and worded generally:

In the absence of national health insurance, 'safety net' providers should be provided with additional funding to cover uncompensated care costs. ...[T]eaching institutions that furnish high amounts of uncompensated care rely on current GME funding to support their charity care. As changes are made in the IME payment methodology, the current level and distribution of DSH payments should be examined....⁶¹

Several other organizations have responded by criticizing COGME's call to reduce IME adjustments to the "analytically justified" or "empirical" level – for example, the Greater New York Hospital Association,⁶² and the American College of Physicians-American Society of Internal Medicine, which states:

...the College is concerned that the Recommendation could be taken out of context and result in reductions in IME payments without the implementation of offsetting funding streams for the other vital missions of teaching hospitals as recommended by CoGME....ACP-ASIM is concerned that reductions will be made before alternative funding can be assured....⁶³

The COGME position also prompted a MedPAC representative to respond that

the Commission in its report didn't recommend bringing the adjustment down or removing the subsidy from...the long-run IME level of 5.5 percent. The commission recommended maintaining a subsidy of about \$1.5 billion and the rationale for this was the current financial state of teaching hospitals and their

lower overall margin. So the commission didn't think it was appropriate to put more pressure on the teaching hospitals at this point in time. But this is an issue the Commission likely will revisit....⁶⁴

Thus, MedPAC's current public stance—holding IME at 5.5 percent—appears to differ from its possible preference for future cuts.

According to one Congressional staffer, action on raising the IME add-on or on most of the Medicare elements that have been under debate lately is likely to be very limited in the 2003 Congress. The White House expresses little interest in fixes to Medicare, except for addressing the payment cut that the AMA physicians have focused on, and in shoring up funding for Medicare HMOs, which are hemorrhaging members. (Action on physician pay could come very early, perhaps just after the State of the Union, before people mobilize to oppose it.) So other substantial fixes are likely to go nowhere in this Congress. There will, though, be pressure to do something for hospitals, particularly from the Rural Caucus.

On GME, even raising the IME back to 6.0 or 6.5 percent for just one year seems unlikely, according to this staffer. At best there may be some proposal to keep the IME adjustment at 5.5 percent for one year, protecting it against further cuts in the short term. CBO has to estimate the ten-year cost of any open-ended changes, so they will appear to cost too much.

Focusing on the question of restoring cuts in the IME add-on, misses the big picture, in this staffer's view. Consider comments on 4 December 2002 by John McManus of the Republican staff for the House Ways and Means health subcommittee. At a forum on CSPAN with Gail Wilensky, former chair of MedPAC, he cited MedPAC's estimate putting the actual cost of IME at about 3 percent. Many Republicans do not even think there should be any IME adjustment. The real threat to IME is the Republican plan to give Medicare patients vouchers. This is discussed briefly in Section V – B, below, on the future of Medicare.

2. A dedicated trust fund or reliance on annual appropriations

Federal (non-Medicare) support for GME through a dedicated trust, protected from the annual budget cycle, was one recommendation of the GME Study Group of the Bipartisan Medicare Commission. Although the full commission could not reach consensus on this issue (or many others), according to COGME, the Study Group recommended “carving direct GME payments out...[to] continue either through a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. The proposal also recommended exploring funding IME and disproportionate share payments outside the Medicare program.”⁶⁵

A call to re-examine all of Medicare's non-insurance functions was the focus of the brief GME section in the final Commission draft of the Breaux-Thomas proposal to transform Medicare into a “premium support system.” But noting that “it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals,” the Commission draft concluded, “Therefore, for now Congress should continue to fund IME from the Trust Fund as an adjustment to hospital payments.”⁶⁶

It is possible that a dedicated funding stream implicitly might bolster the level of support for IME. Much would depend on the degree of political insulation provided to the dedicated trust. Congress is not enthusiastic about creating dedicated trusts. Securing one for GME would depend largely on the depth of political support for GME as a whole.

But it might well be that efforts to shift GME financing to a dedicated trust, by opening up the question of source of dollars for GME, would result instead in a decision to rely on direct annual appropriations. Knapp argues that

The financing of DGME through the appropriations process raises a host of worrisome potential consequences. First and foremost, the dependability of funding for DGME would be eroded. Under an appropriations process, GME would have to compete with other worthy priorities. The GME function would probably fall within the jurisdiction of the House and Senate Labor, Health and Human Services and Related Agencies Appropriations Subcommittees, where children's hospital GME and other health professions programs (Titles VII and VIII) of the Public Health Service are currently funded. Here it would compete with the National Institutes of Health and, indeed, the entire Public Health Service as well as programs in the Departments of Labor and Education. Some observers suggest GME would fare well in a competition for funds. However, "focus groups" and survey work conducted by the AAMC of voting Americans and congressional staff suggest that the financing of physician education is a distant third in competition with biomedical research and patient care programs.

If GME would not fare well in an appropriations process, how could it secure the even greater support that would probably be required to create a durable dedicated trust fund?

The AMA seems to concur with Knapp's view. Regarding "whether or not the annual appropriations process was a suitable alternative for a semi entitlement system now in place for HCFA funding.... the President's budget with the sudden decrease as pertains to pediatric hospitals and pediatric residents has convinced us that you cannot run residency programs on annual appropriations."⁶⁷

Relying on appropriations would be very dangerous. The Bipartisan Commission/Breaux-Frist proposal to pull out GME and make it subject to a multi-year appropriation is dangerous to GME. This danger is evident this year, when we don't even have an appropriations bill yet. How could residency program sponsors and applicants make plans in that context? Even if given a three-year appropriation, there would inevitably be the years when nothing goes through in time. And would appropriations deals get cut, trading residency slots the way members now trade bridges and road projects?

3. Establish all payer financing for GME

Sundwall has restated COGME's preference for a formal all payer mechanism for financing GME.⁶⁸ This preference was enunciated prominently in a 1999 report.⁶⁹ Costs of training and other special costs of teaching hospitals should be fairly distributed across all payers, COGME asserts.

As summarized by another leading supporter of all payer financing, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM),⁷⁰ the main rationale is that, "All members of society benefit from having well-trained physicians and

appropriately funded academic medical centers. Consequently, all health care payers should share in the costs of graduate medical education.”

COGME would create a GME fund by combining existing Medicare dollars with funds from all other payers—funds that would be gathered through a surcharge on premiums or other methods. ACP-ASIM observes,

There are a variety of possible mechanisms for collecting contributions for the cost of graduate medical education from payers other than Medicare and Medicaid. These include taxes on health insurance premiums, surcharges on teaching hospital admissions, and payroll taxes for employers that either do not offer health insurance or that provide self-insured plans.⁷¹

This approach implicitly dismisses the ProPAC/Newhouse-Wilensky assertion that a functional all-payer arrangement already exists.

COGME shares MedPAC/Newhouse-Wilensky’s concerns over “escalating GME expenditures, difficulty accounting for education-related costs, financial incentives that have raised the number of residents employed by hospitals, and extraordinary variation in payment to teaching hospitals.”⁷²

Still, asserts COGME, securing enough well-trained physicians is a public good, so the public should pay. Financing for GME should be “stable, sufficient, and fairly distributed to teaching programs....” In addition, training programs in outpatient departments, emergency rooms, and non-hospital ambulatory settings should be financed fairly. GME payments should include incentives to advance specific goals to train more physicians.

Maryland has been reasonably successful in doing this in its all payer system. Even after abandoning its own all payer system, New York State has mandated retention of substantial Medicaid and private payer support for teaching hospitals.

Supporters of an all payer system for GME, like ACP-ASIM, suggest that the federal government should retain special responsibility for ensuring the adequacy of the physician supply and for teaching hospital funding.⁷³

In Congress, there have been several all payer proposals, each of which incorporates provisions addressing varied aspects of GME. In the most recent session, S. 743 was introduced by Sen. Reed of Rhode Island and by senators Clinton and Schumer of New York on 6 April 2001. Called “the Medical Education Trust Fund Act of 2001,” it was modeled on a 1999 proposal from then-Senator Moynihan. On the House side, on 14 June 2001, Rep. Cardin of MD and 11 co-sponsors filed HR 2178, the “All Payer Graduate Medical Education Act.”⁷⁴

In the senate bill, Medicare and Medicaid GME dollars would be transferred to a new fund, which would also draw a 1.5 percent assessment on all health insurance premiums. Payments to teaching hospitals from the trust fund’s Medicare accounts would use the current DGME and IME formulas. Payments from the fund’s non-Medicare accounts would use the same formulas, adjusted to reflect each hospital’s non-Medicare volume. The bill also calls for a commission to explore GME issues for the future.

Cardin's bill would continue existing GME financing from Medicare, Medicaid, and the Veterans Administration. It would create a new trust fund financed by a 1 percent premium tax on all private health insurance, expected to raise about \$4.0 billion. The trust fund's would pay for DGME by a national average of resident salaries and fringe benefits, with adjustment for inflation and local wage levels. For IME, because all payers would be contributing, Medicare's add-on would decline from 5.5 percent to 4.8 percent, but the bill would allocate \$300 million of the projected \$1.5 billion in savings to support graduate education for non-physician health professionals. The bill would reform DSH payments to hospitals by recognizing uncompensated care costs and Medicare managed care patients.

All payer financing of GME has drawn broad support within health care, with some supporters backing both of the current bills. Among major organizational supporters of various versions of all payer financing are the American Hospital Association,⁷⁵ the American Medical Association,⁷⁶ the American Association of Medical Colleges,⁷⁷ and the American Medical Student Association (AMSA).⁷⁸ COGME cites backing for all payer funding from three collaborative efforts to address such issues—the Pew Health Professions Commission, the Taskforce on Academic Health Centers of the Commonwealth Fund, and a Consensus Statement on the Physician Workforce released in 1997 by associations of physicians and teaching facilities.⁷⁹ Other reported supporters include the Greater New York Hospital Association,⁸⁰ the National Association of Children's Hospitals, the American Osteopathic Association, the American Association of Colleges of Nursing, and the American Speech Language Hearing Association.⁸¹

Opponents of all payer financing include MedPAC (and as individuals, Newhouse and Wilensky), along with the HMO industry organization, the American Association of Health Plans (AAHP).⁸² Employer associations are not visibly in opposition now, but if momentum developed for these bills, the HMOs/insurers and others could be expected to spur some opposition from employers, even though a 1-1.5 percent surcharge is small in the context of recent health insurance premium increases.⁸³

Newhouse and Wilensky assert that payers other than Medicare already choose to pay teaching hospitals more money than they pay community non-teaching hospitals, and this is tantamount to an all payer financing system.

It seems clear that teaching hospitals' abilities to wrest higher payments from Medicaid, commercial insurers, managed care organizations, and the like depend heavily on their political power and market power in their regions. Some teaching hospitals, including a few in Boston with which we are familiar,⁸⁴ routinely garner much higher payments for routine care than do community hospitals in the region. But other teaching hospitals do not do remotely as well.

Given this, it is not reasonable to consider current arrangements as tantamount to an all payer system. Considering it to be one seems to have elements of sophistry, meaning little more than that all payers pay hospitals.

4. Merge DGME and IME, paying hospitals only IME methods

The Medicare Payment Advisory Commission (MedPAC) and Newhouse – Wilensky generally take this position.⁸⁵ The main step proposed is to pay for DGME as we now pay for IME, through an add-on to each DRG payment, thereby ending the distinction between DGME and IME.

MedPAC asserts that the distinctions between DGME and IME are “an accounting artifact,” not a response to the underlying realities.⁸⁶

MedPAC notes that combining DGME and IME raises at least three questions: which dollars to consider, how to calculate the add-on, and whether to continue to subsidize teaching hospitals.

First, then, should payments rest on current costs at each hospital, on current payments to each hospital, or some other measure? By June of 2000, the congressionally-imposed cap on DGME payments left them 16 percent below costs reported by hospitals. Similarly, how should DGME costs incurred in hospital outpatient departments and emergency rooms, and in free-standing ambulatory training sites, be considered?

Second, how should the adjustment be calculated? What is the best measure of teaching intensity, the one that most accurately and systematically captures the extra costs associated with teaching? Because the IRB formula gave hospitals incentives to add residents, MedPAC wanted to cease relying on the IRB. Unfortunately, it could not identify a substitute, one that fairly reflected all of a hospital’s residents, regardless of the site at which they were trained.

Third, although MedPAC’s August 1999 report asserted its intention to be payment-neutral, MedPAC noted in its June 2000 report that, even after fully implementing the GME cuts in BBA 1997, IME would still be substantially greater “than can be empirically justified.”

5. Narrow or eliminate PRA disparities

COGME favors one “national average per resident payment for direct GME costs,” which would “vary only for differences in the cost of living across geographic areas.”⁸⁷

Newhouse and Wilensky assert that differences in the PRA are not acceptable. They are a product of 1984-era differences among hospitals in the share of attendings’ efforts that was voluntary (unpaid), and also a product of differences in accounting practices.⁸⁸

AAMC raises several questions that suggest some confusion in the COGME recommendations⁸⁹:

- How would future payment levels be determined—“how would you, once you have moved everybody to the average, compute an average?”
- After urging use of a simple national average, varying only for cost of living, COGME then recommends also providing higher payments for residencies in community setting, and incentive payments for certain goals.⁹⁰
- While COGME also suggests that research is needed on several issues to properly determine DGME payment methods, AAMC responds that such research should be done before deciding to use a national average payment.

6. Use GME to influence resident training to improve the configuration of U.S. physicians

COGME asserts that GME payments should include incentives to advance specific goals to train more physicians of certain types.⁹¹ While it generally favors retaining BBA's limits on the total number of residents in training, it accepts special exceptions aimed to redress geographic imbalances in the physician supply.

New York State has included special provisions to train more primary care physicians and more minority physicians.

MedPAC opposes efforts to use GME to advance general physician workforce goals, asserting that Medicare's aim is to finance high-quality care for its beneficiaries, not to advance broader public policy goals.

7. Give residents vouchers for GME

COGME mentions that some propose giving residents vouchers to cover costs of their training, whether in hospitals or community settings. This might seem appealing as a way of giving residents themselves more control, ostensibly spurring competition between residency programs.

As COGME observes, though, "...it is not clear that the voucher system is significantly different from other payment models. Programs already compete for residents and GME payments are based on where the resident trains." Perhaps most important, "The resident's ability to hold the program accountable is limited once the resident has selected a program."⁹²

COGME goes on to suggest that vouchers would be useful "only if there is a regulatory apparatus to determine the number of positions to be funded and which residents should receive funding."

8. End federal GME financing

Reinhardt asks—if Newhouse and Wilensky are correct in stating that residents actually do absorb the cost of their training through their low salaries and long hours— why should teaching hospitals be subsidized for that training? Reinhardt's only justification for continuing GME payments is that teaching hospitals provide substantial amounts of otherwise uncompensated care.⁹³

If all Americans were insured, Reinhardt would apparently be willing to end all public subsidies to physician training. He would lend doctors-in-training the funds they needed to finance their education, and then offer loan forgiveness in exchange for service in under-doctored areas.

9. Cease to use the IRB ratio as the only way to distribute IME dollars

COGME favors “providing additional support for hospitals and community–based training sites that serve a disproportionate share of low-income patients.”⁹⁴ It would, for example, be possible to use those GME funds saved by a cut in IME from 5.5 percent to MedPAC’s estimated actual cost of 3.1 percent or so in order to finance such additional support.

The advantage is that the money would be more closely aligned with hospitals’ actual needs for money to serve vulnerable patients. This justification is more reasonable than an IME add-on rate in excess of MedPAC’s estimate.

But the disadvantages are several. Money could be spilled while it is being moved from one bucket to another. It might be diverted to other uses. And vulnerable patients and the hospitals that serve them are not likely to be especially popular in the 2003 Congress. This unpopularity is enhanced by the widespread belief that legitimate market forces do and should determine the fate of hospitals, not targeted public aid that only distorts the workings of this market.

C. Summary of threats and opportunities facing residents, teaching hospitals, and the patients they serve

1. Threats

The main looming threat is that of continued reductions in the IME add-on. Cutting the IME rate below today’s 5.5 percent add-on will reduce payments to all teaching hospitals in proportion to current IME dollars. Hospitals suffering tighter financial margins would feel this pain more deeply.

It does not seem likely that teaching hospitals will soon face renewed pressure to cut below 5.5 percent. Indeed, they are pushing to raise the IME up to the 6.5 percent prevailing until 1 October 2002. But they must push in the face of both a generally tight budget and specific opposition from AARP to any Medicare give-backs to hospitals or doctors.⁹⁵ AARP wants available dollars to go first to a Medicare prescription drug benefit.

If DGME is combined with IME in one add-on payment, the main general threat is one of continued reductions in the size of the add-on. DGME would no longer be sheltered (frozen, but still sheltered).

If DGME is combined with IME, so its payments rest on one overall formula, the main specific threat would be to hospitals that have enjoyed high historic PRAs, particularly those with low IRBs. These hospitals would see substantial declines in their combined DGME plus IME payments. This threat would be roughly balanced financially by offsetting gains to hospitals with low historic PRAs and to hospitals with high IRBs.

If part or all of GME is removed from Medicare and made subject to direct appropriation, it probably will be even more subject to political vicissitudes than today.

2. Opportunities

One reason why IME funding is vulnerable today is that it is viewed as excessive and ill-targeted. Those who fight to retain the current IME formula risk losing payments above levels that researchers measure to be needed to pay for teaching. The IME add-on would probably persist, though at still lower rates.

It might be possible to save this money, and even add more. But that would require building a foundation strong enough to hold the money. Such a foundation would need to rest on needed hospitals' legitimate and demonstrable financial requirements:

- How much money do different types of hospitals need to deliver high-quality care if they are efficiently operated?
- In what way would the money be allocated? Through a bigger DSH program? A new super-DSH? Maryland-style all-payer mechanisms? Or a targeted program to give financial relief to identified financially distressed hospitals that are needed to protect vulnerable people or the health of the public generally?
- Just as important, which hospitals are needed in each city, metropolitan area, or state to protect the health of the public?

Building this foundation might provide an opportunity to sustain and even increase the dollars that today flow to GME. But it is not now clear whether the foundation can even be built or, if it can, whether the dollars can be shifted to this new foundation without significant spillage.

Politically, hospitals that would lose money owing to the drop in IME rates, and that would not gain new payments from the new financing formula would need to concede the lost money. To do so, they would probably have to believe that the likely alternative would be an outright loss of the money subtracted by the cut in IME rates, with no replacement. They would probably also need to build some solidarity with the financially distressed hospitals that would benefit from the replacement money. More broadly, politicians and voters would need to feel some reasonable sympathy for the plight of the hospitals that would benefit from that replacement money—and for the patients served at those hospitals.

V. RELEVANT POLICY CONTEXTS

Costs of medical education—perceived and real—and the power of teaching hospitals and medical schools have driven Medicare GME policy. This cost and this power have been countered by fears of excessive and unfair payments to teaching hospitals, and by federal financial strictures generally.

At the same time, the debates over GME take place in several important contexts. Among these are

- the condition of the U.S. economy, the federal budget
- the future of Medicare itself, overall
- the rising cost of health care
- the configuration of U.S. physicians—numbers, types, and locations
- teaching hospitals' own need or demand for resident physicians, to provide services
- the configuration of U.S. hospitals—numbers, types, locations, and survival
- the financing of GME in other industrial democracies

A. The U.S. economy and the federal budget

It is useful here to plan for a range of contingencies. Both optimistic and pessimistic stories can be told about the next decade. Optimistically, tax cuts could stimulate economic recovery, budget and trade deficits could improve, reliance on foreign oil and manufactured goods might decline, and the like. Pessimistically, the recent tax cuts could re-create the structural deficits that characterized the presidencies of Reagan and Bush I, leading to steady pressure to cut federal spending.

A weak economy and a high federal budget deficit will profoundly affect payers' willingness to finance continued rises in U.S. health spending. At the same time, a weak economy will mean greater need for public spending to protect uninsured patients and the caregivers that serve them. This tension will grow.

If states try to fill gaps created by inadequate or unfair federal financing—or by cuts in federal support for hospitals treating vulnerable patients, for example, they will themselves be politically and financially handicapped by their own substantial deficits. According to the National Governors Association, “states are facing their worst fiscal crisis since the end of World War II.”⁹⁶

B. The future of Medicare

According to a top staffer to one of the members of Congress who is most active on GME issues, the Congress that convenes in 2003 may vote for extensive voucherization of Medicare. And that would probably be devastating to GME, for teaching hospitals, and for the patients they serve.

Something similar to the “premium support” approach of Breaux-Frist is very likely to be revived, posing enormous danger to funding for GME. Bill Frist raised Medicare “reform” as a priority in recent *New York Times* interview. The basic approach, in eyes of many proponents, would be simply to give people on Medicare a voucher worth perhaps 95

percent of the average amount spent per person nationally in Medicare, about \$5,200 now), with no adjustments even for geographic differences in living costs. This would leave patients to see what coverage they can buy from insurers for that sum plus any personal resources they can contribute.

This approach would not build in explicit sums for GME, or any other differentiation. Teaching hospital use will plummet because HMOs will not use teaching hospitals much, and because patients in any remaining FFS Medicare will be left with such meager benefits that they'll face large barriers to using teaching hospitals.

In the view of this staffer, the fight over Medicare "premium support" is likely to make the fight over IME add-ons of 5.5% or 6.0% or 6.5 percent look trivial.

Increasingly, some members of Congress are citing any complexities as reasons why government should not be involved in various issues. So discussion of complex formulae for GME payment could prompt assertions that Congress has no business making such major technical decisions and it should be left to the market and competition.

In another view, the declining enrollment of Medicare patients in HMOs—attributable variously to lower federal payments and to HMO problems—suggest that voucherization is simply unacceptable to a great share of Medicare patients. In this view, if Congress were to mandate voucherization or a large experiment with compulsory voucherization, the political backlash could be enormous. But that might come too late to help teaching hospitals, their residents, or their patients damaged by the reduced revenue that voucherization would bring.

So—will Congress pass Medicare vouchers? Much depends on the contention between a) demands to contain spending, reinforced by budget deficit fears and fueled by free market ideology and perhaps by over-reaching arrogance—and b) the realism and self-preserving instincts and skills of our representatives and senators.

C. The rising cost of U.S. health care

In 2002, U.S. health care spending probably has risen above \$1.5 trillion. That is, \$1,500,000,000,000.

At roughly \$5,400 per American.

And it is over four times as great as this year's defense spending.

As is well-known, health care costs stabilized, as a share of gross domestic product (GDP) during most of the 1990s. This was partly attributable to slower health spending growth and partly to rapid economic growth. But both of those days are over, for now. Health spending began rising very rapidly again in the late 1990s, just before the economy turned down.

By the most recent federal projections, total health care spending is expected to just about double from \$1.4 billion in 2001 to \$2.8 billion in 2011. And it is projected to rise from 14.0 percent of the economy in 2001 to 17.0 percent in 2011.⁹⁷

Health spending generally lags behind the economy. That is, it takes several years for it to respond to economic changes. For example, during most recessions, health care spending continues to rise for several years before gradually adjusting to the new economic realities.

Right now, this means a looming crisis of unexpected proportions—as public and private payers seek ways to slow the growth in their health care obligations.

All this happens at an unfortunate time—when the entire warehouse of cost control ideas that enjoy good political currency—hospital closings, managed care, and price competition—have been measured and found wanting.

This largely explains the desperation of the cost controllers. In the private sector of insurance through the job, this desperation could fuel increased de-insurance, as employers try to shift a greater share of the health insurance premium to workers and families, try to increase out-of-pocket costs, and even consider defined contribution plans. The last would pay a fixed amount toward purchase of individual health insurance—something not too different from a voucher. This would greatly penalize older and sicker workers and family members.

And in the public sector, this desperation could help to build support for Medicare voucherization, as noted earlier. This reminds us of the definition of fanatics as people who have forgotten their aim but redouble their effort.

D. The configuration of U.S. physicians

Over the past two decades, a number of substantial research efforts have produced seriously conflicting estimates of both the number of physicians needed to protect the health of U.S. residents, and the number of physicians likely to be available to meet that need. We have seen forecasts of shortages, surpluses, and now shortages. Feil and her colleagues have summarized reasons for the disagreements among these efforts.⁹⁸

There is widespread agreement that U.S. physicians are malconfigured along regional, urban-rural, and primary-specialty lines, but there is little agreement about whether governments should intervene to address these malconfigurations and whether, if so, GME should be one of the levers used to remedy the perceived malconfigurations.

Teaching hospital and survival and market share in the urban hospital environment—
cost, access, coverage, hospital closings and mergers

In the view of one top Congressional staffer, the best way to make the case for substantial and secure funding for teaching hospitals and GME is to focus on all Americans' need for a well-trained physician workforce for the future.

Highlighting the role of teaching hospitals in serving the under-served doesn't win much support. Teaching hospitals gain limited sympathy because many members see them as having lots of money and believe that hospitals can always manipulate their bottom lines.

Many members of Congress, and many other policymakers, have little understanding of GME and don't see it as one of the big issues in the context of Medicare, and don't see it as affecting them. Even many medical residents don't realize how much Medicare is the source of the funds hospitals that use to pay them and to finance GME overall. (For most physicians, GME is a very low profile issue, one the AMA has never highlighted.)

E. Teaching hospitals' own need or demand for residents

Stevens has written persuasively about the growth in teaching hospitals' demand for residents in the 1950s, in response to attendings' increased power over hospitals (in consequences of the drop in physicians/population and the rise in hospital beds/population).⁹⁹

Newhouse and Wilensky are among those who attribute much of the rapid rise in the number of residents in U.S. hospitals to Medicare's overly generous DGME and IME payments.¹⁰⁰ This is not clear. Witness the rapid rise in the number of residents between 1980 and 1985, probably well before the new PPS-associated DGME and IME payment schemes could have substantial effects on actual numbers of residents. It may well be that the old regime of cost reimbursement was even more generous or tolerant toward teaching hospitals.

Table

Number of residents, U.S. hospitals, 1980 – 1999 ¹⁰¹

year	Number of residents
1980	61,465
1985	75,514
1990	82,902
1991	86,217
1992	89,368
1993	97,370
1994	97,832
1995	98,035
1996	98,076
1997	98,143
1998	97,383
1999	97,989

Looking forward over the next 5 – 10 years, hospitals' need for residents will be powerfully influenced by any possible cuts in resident hours. If a hospital has 100 residents working 100 hours weekly today, on average, that makes 10,000 hours per week in total. If residents begin actually working 80 hours weekly, that requires 125 residents to deliver the same 10,000 hours.¹⁰²

Hospitals might need this number of residents, and even want to hire them, but their abilities to do so will rest heavily on two main financial considerations —ability to front the money to pay the residents, compared with the revenue derived from the additional patients the hospital can serve with more residents.

Looking ahead, if the market for board-certified and board-eligible physicians is saturated in some sectors, hospitals will be able to hire fully-trained physicians at lower prices, and might consider substituting more of them for residents.

Another powerful influence on demand for physicians will be rates of use of urban hospital care for inpatient and outpatient services. These rates have been rising recently, perhaps caused by weakening of managed care controls on hospital use, and by the growth of the population aged 45-54, a span during which hospital use typically increases substantially.

Related matters include the supply of IMG physicians, the nation’s actual and perceived needs for doctors in various specialties and settings, and the overall financial condition of U.S. health care.

F. The configuration of U.S. hospitals—numbers, types, locations, and survival

Residents of U.S. cities depend increasingly on teaching hospitals to provide inpatient, outpatient, and emergency services.

This is because there are fewer other options in most cities. Consider these fairly dramatic data from our study of hospital closings in 51 large and mid-size U.S. cities.

Exhibit

Teaching Hospital Shares of Hospitals and Beds, 51 U.S. Cities, 1950 -1997

	<u>number of hospitals</u>			Teaching % of hospitals
	non-teaching	Teaching	total	
1950	582	137	719	19.1%
1960	584	165	749	22.0%
1970	540	242	782	30.9%
1980	374	336	710	47.3%
1990	353	277	630	44.0%
1997	246	317	563	56.3%

	<u>number of beds</u>			Teaching % of beds
	non-teaching	teaching	total	
1950	98,282	76,416	174,698	43.7%
1960	118,287	84,470	202,757	41.7%
1970	108,528	122,819	231,347	53.1%
1980	75,391	162,605	237,996	68.3%
1990	78,300	134,723	213,023	63.2%
1997	46,045	125,797	171,842	73.2%

In summary, teaching hospitals were one-fifth of hospitals in 1950 and this grew to over one-half by 1997. Teaching hospitals held 44 percent of beds in 1950 and this grew to 73 percent in 1997.

This growth is attributable partly to the closing of many mid-size hospitals, particularly those located disproportionately in African-American communities, partly to the designation of some former non-teaching hospitals as teaching hospitals (often in association with creation or expansion of medical schools) and partly to the disproportionate expansion of teaching hospitals in many cities.

As a result, in substantial districts of some U.S. cities, such as Washington, D.C., Boston, and Detroit, there are few alternatives to teaching hospitals and the systems of care they control.

This often means higher cost of inpatient care than would otherwise be the case. And it does mean that urban residents—including low-income urban residents—are obliged disproportionately to rely on costly tertiary teaching hospitals for their health care—primary, secondary, and tertiary.

Regardless of the causes of the growth of teaching hospitals, the current reality is that they are they and that many patients rely on them—indeed, have no alternative to them.

For example, owing to the shortage of physicians in private practice in many urban neighborhoods, to many doctors unwillingness to care for Medicaid patients owing to low payment rates and other factors, urban residents are often forced to rely heavily on hospitals for physician services. For example, fully 30 percent of African-American doctor visits are made to emergency rooms, about double the rate for whites.¹⁰³

At the same time, many urban hospitals face serious financial distress. In some cities, even teaching hospitals, seldom at risk of closing in past decades, confront substantial risks to their survival.

It is folly to rely on competition by price and quality to identify and protect needed hospitals. First, efficiency has never predicted survival, as discussed earlier. Second, the foundations for anything close to genuine free market competition are absolutely lacking in the hospital field in most cities. Therefore, talk of “survival of the fittest” might have masked indifference and rationalized the disproportionate closing of hospitals located in minority communities in the past—and might rationalize the closing of urban teaching hospitals in the years ahead.

As a result of the changing configuration of urban hospital care, urban residents must rely increasingly on large teaching hospitals for their health care. This means that service to uninsured and vulnerable urban residents increasingly is a responsibility of large teaching hospitals. As the number of uninsured Americans rises—owing to Medicaid cuts, rising unemployment, and abandonment of insurance coverage by some employers and employees in the face of high premiums—pressure on urban teaching hospitals will grow. They are known widely—to differing degrees in different cities—as the places that will not turn you away.

Yet financial distress could force closings and service cuts at many hospitals just at the time they are most needed. Recent crises in Los Angeles County and in Washington, D.C. show the vulnerability of urban public teaching hospitals. And recent crises in Detroit show the vulnerability of urban non-profit teaching hospitals.

Given the number of hospital and bed closings in most cities in recent years, the growing bed shortages, the rising number of uninsured people, the tide of closings of ambulatory facilities (in such cities as Los Angeles, New York, and Detroit), and the growing rate of emergency room diversions, the presumption should be that each surviving hospital is needed unless proven otherwise.

Pending the design of more affordable alternatives, there is no alternative to financing needed care at levels sufficient to pay for high-quality services and thereby sustain each needed hospital.

While this is done, efforts should be initiated to design, finance, and implement more affordable patterns of care. These might feature greater reliance on community-based physicians and on non-teaching hospitals, but these things will not happen on their own.

G. Financing GME in other industrial democracies

How is GME financed in other relevant nations, how adequately, and how satisfied are the stakeholders?

We will provide evidence on the methods and adequacy of financing GME in several clusters of nations, including

- Single payer – Canada, UK and Italy
- Mixed public/private – France, Germany
- Other

In those nations where universal coverage is virtually assured, it is only the extra costs of teaching that must be covered by equivalents of DME and IME payments.

VI. RECOMMENDATIONS

We offer four sets of recommendations in light of the evidence and analysis offered earlier in this report. Recommendations involve federal, state, local, and hospital-specific actions. They embody our understanding of the best short-run and long-run methods of protecting and advancing the interests of teaching hospitals, the residents who staff them, and the patients they serve—particularly those patients who are vulnerable to deprivation of needed care.

Any recommendations should be informed by assessment of the efficiency of payments to teaching hospitals—are they targeted properly to the institutions that need and deserve them? Are the payments efficacious—do they aid hospitals that serve

vulnerable patients? Are they politically feasible—likely to be enacted, financed, and renewed? Will they be perceived as legitimate? Are they administratively feasible—can this payment method be administered fairly and simply

A. Federal

Here, action should be guided by the admonition to “first, do no harm.” If this applies at retail, to care of one patient by one physician, it also applies—perhaps with even greater force—at wholesale, to massive actions that could harm millions of Americans.

1. Look first

We urge retention of current DGME and IME payment methods and limits until the specific financial effects of any change on the nation’s teaching hospitals are measured and analyzed, hospital-by-hospital. Blanket policies that have the effect of financially destabilizing dozens of needed hospitals (or more) must be opposed.

This applies with particular force to proposals for Medicare voucherization, which would entirely disrupt GME payments, overall Medicare payments to teaching hospitals, and therefore would harm teaching hospitals, their residents, and the vulnerable patients they serve.

Further, any Medicare voucher that was calibrated to a national average sum would inevitably harm both those patients who have no choice but to rely heavily on teaching hospitals—and those teaching hospitals themselves.

2. Moderate change

The perceived unfairness and legitimacy of today’s DGME and IME payment methods constitute risks to their financial and political survival.

The current DGME method seems blatantly unfair, particularly to hospitals with very high and very low PRAs. We suggest a five-year transition to a national average PRA, one that is adjusted for actual costs of living.

The current IME add-on of 5.5 percent is considered by MedPAC analysts to be well in excess of the 3.1 – 3.2 level that would be needed to cover costs at the average teaching hospital. This new finding is somewhat uncertain. We have seen several studies over the past decade that arrived at varying levels of legitimate add-ons. Do we have convincing reasons for believing that the new study is more accurate than its predecessors?

Still, reckless cost-cutters may not attend to the cautions that today’s IME rate of payment of 5.5 percent is essential to preserve care at many teaching hospitals. They may seize on the MedPAC study as an additional excuse to cut IME.

Protect the dollars that now flow through IME to teaching hospitals requires establishing them on a durably legitimate foundation.

Therefore, as a first intermediate step, it would be well to consider channeling more of today's IME dollars to the DSH pool, to be distributed in accord with the DSH formula. Then, more money will go to hospitals that serve greater numbers of vulnerable patients. It might be that only a 3.1 – 3.2 percent add-on will remain in IME. Hospital-by-hospital effects of changes in payment methods must be analyzed, with special attention given to revenue losses at needed but already-distressed hospitals.

As a second intermediate step, the financial requirements of teaching at efficiently operated teaching hospitals should be studied in greater depth and discussed publicly. This should inform better decisions about IME rates.

As a third intermediate step, DSH plus IME payments should be increasingly targeted to offset losses at needed but efficiently-operated teaching hospitals, particularly those serving high shares of vulnerable patients.

Ultimately, Medicare should join with all payers to equitably and adequately and affordably finance all needed care at all needed hospitals. That is, each needed hospital should be paid enough revenue to cover the costs of high-quality care for all patients, as long as the hospital is operated efficiently. Today's GME and DSH payments are complicated and confusing (and they probably under-pay some hospitals even while they over-pay others) because GME and DSH rest on a foundation of general payments by Medicare, Medicaid, and private payers that are themselves often unfair. As a result, it is hard to design DME and DSH payment methods that justly compensate for underlying inadequacies.

B. State

First, each state should identify the hospitals that are required to protect the health of their citizens. No state does this today, though fears of terrorist attacks are re-awakening interest in the question. So have reports of ER diversions. So have reports of bed shortages and predictions of greater shortages in the future.¹⁰⁴

Second, each state should identify hospitals currently facing financial distress or expected soon to face such distress. Massachusetts recently demanded quarterly financial data on hospitals in order to be better able to do this.

Third, each state should develop an operations plan and a financing plan to stabilize each needed but financially distressed hospital. This plan could include

- provisions for gubernatorial declarations of public health emergency, when necessary, to seize and take control of a needed but distressed hospital
- legislative action to enact hospital receivership statutes—laws focused on identifying and conserving needed hospitals
- special financing, such as a hospital reinsurance pool, which assesses 0.25 – 0.50 percent of each hospital's revenue annually, and uses this money to provide managerial assistance and, if needed, cash grants to distressed hospitals

- state action to build on Maryland’s success with all payer hospital payment—a method of payment designed to provide each needed and efficiently-operated hospital enough money to provide high-quality care to all patients

In the end, states must act to preserve needed teaching and non-teaching hospitals, their residents, and the patients they serve. No market exists to do this. Without a market and without careful public action, we will all suffer from health services anarchy.

C. Local

Urban public hospitals’ survival depends intimately on the hospital’s finances, its perceived efficiency, its perceived quality, its political support, and its physical condition. Disruption in any area can precipitate loss of the hospital. And closed is usually forever.

Building local support requires, ultimately, reinforcing the reasons for believing that the survival of the hospital is desirable and legitimate. This means enhancing patient care and improving efficiency. It means securing the best available hospital administrator, and working with unions and community groups to warn that perceptions of inefficiency, over-staffing, or low-quality care will delegitimize even badly-needed public hospitals.

D. Hospital-specific

Some hospitals drift into financial trouble. When this happens, CEOs and trustees often insist that the hospital should close because they were unable to save it. This is an act of bad faith. It is why physicians, unions, employees, and community groups at each hospital should monitor its financial performance and demand corrective action when needed. They should also insist that hospitals, their workers, and the patients they serve should not be punished because administrators or trustees failed.

Documenting the need for each hospital is vital. While state governments should take on this job, they are not likely soon to do so. Therefore, physicians, unions, employees, and community groups should do it. Identifying shortages in care and capacity that would result from a closing or downsizing is helpful, as is information on increased travel time. Further, a closing can disrupt patterns of care-giving and care-seeking. Doctors and nurses may retire or relocate, leaving them unavailable to alternative nearby hospitals. Evidence suggests that many patients may cease seeking needed care.

NOTES

¹ Alan Sager and Deborah Socolar, *Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the Public*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 20 May 1999, submitted as testimony on H. 781, Health Care Committee, Massachusetts General Court.

² This statement of purpose is found at <http://www.cogme.gov/>, accessed 5 December 2002.

³ The members of COGME in late-2002 are listed at <http://www.cogme.gov/mbrs.htm>, accessed 5 December 2002. They are:

Chair Carl J. Getto, M.D., Senior Vice President Medical Staff Affairs, Associate Dean Hospital Affairs, University of Wisconsin Hospital & Clinics, Madison, WI

Vice Chair Marian Bishop, Ph.D., M.S.P.H., Professor and Chairman Emeritus, Department of Family and Preventive Medicine, University of Utah School of Medicine, Salt Lake City, UT

Regina M. Benjamin, M.D., M.B.A., Associate Dean for Rural Health, University of South Alabama, College of Medicine, Mobile, AL, and Owner and CEO, Bayou La Batre Rural Health Clinic, AL

William Ching, Medical Student, New York University School of Medicine, New York, NY

Allen Irwin Hyman, M.D., FCCM, Executive Vice President and Chief of Staff Columbia-Presbyterian Medical Center, New York, NY

Robert L. Johnson, M.D., Professor of Pediatrics and Vice Chair, Department of Pediatrics New Jersey Medical School, Division of Adolescent and Young Adult Medicine, Newark, NJ

Laurinda L. Calongne, LCSW-BACS, Director of Behavioral Medicine, Family Medicine Residency Program, Baton Rouge General Medical Center, Baton Rouge, LA

Lucy Montalvo, M.D., M.P.H., San Diego, CA

Jerry Alan Royer, M.D., M.B.A., Senior Vice President and Chief Medical Officer Mercy Health Plans, Chesterfield, MO

Susan Schooley, M.D., Chair, Department of Family Practice, Henry Ford Health System Detroit, MI

Mr. Humphrey Taylor, Chairman, The Harris Poll, Harris Interactive New York, NY

Donald C. Thomas, III, M.D., St. Petersburg Beach, FL

Douglas L. Wood, D.O., Ph.D., President, American Association of Colleges of Osteopathic Medicine, Chevy Chase, MD

Designee of the Assistant Secretary for Health

Sherrie L. Hans, Ph.D., Assistant Surgeon General, Principal Deputy Assistant Secretary for Health, Washington, DC

Designee of the Centers for Medicare and Medicaid Services

Tzvi M. Hefter, Director, Division of Acute Care, Baltimore, MD

Designee of the Department of Veterans Affairs, Stephanie H. Pincus, M.D., M.B.A. Chief Academic Affiliations Officer, Washington, D.C.

Statutory Members

Eve E. Slater, M.D., F.A.C.C., Assistant Secretary for Health, Department of Health & Human Services, Rockville, MD

Robert H. Roswell, M.D., Undersecretary for Health, Department of Health & Human Services
Rockville, MD

Tom Scully, Administrator, Centers for Medicare and Medicaid Services, Department of Health & Human Services, Washington, D.C. 20201

Thomas L. Garthwaite, M.D., Undersecretary for Health, Veterans Health Administration
Department of Veterans Affairs, Washington, D.C

⁴ See <http://www.aamc.org/teachinghospitals.htm>, accessed 5 December 2002.

⁵ House Ways and Means Committee Report No. 98-25 (4 March 1983) and Senate Finance Committee Report No. 98-23 (11 March 1983).

⁶ MedPAC members are Glenn Hackbarth, chair; Robert Reischauer, Vice-chair; Autry O.V. DeBusk; Alan Nelson, ACP/ASIM; David Smith, AFL-CIO; Ray Stowers, Oklahoma State University College of Osteopathic Medicine; Sheila Burke, Smithsonian Institution; Allen Feezor, California Public Employees Retirement System; Ralph Muller, Stockap and Associates; Joseph Newhouse, Harvard University; Alice Rosenblatt, Wellpoint Health Networks; John Rowe, Aetna, Inc.; Nancy-Ann DeParle, JPMorgan Partners; David Durenberger, National Institute of Health Policy; Carol Raphael, Visiting Nurse Service of New York; Mary Wakefield, Center for Rural Health, University of North Dakota; Nicholas Wolter, Deaconess Billings (Montana) Clinic.

⁷ Mark Levy, e-mail to Sandy Shea, 1 December 2002.

⁸ Se Sarah E. Brotherton, Frank A. Simon, and Sandra C. Tomany, "US Graduate Medical Education, 1999-2000," *Journal of the American Medical Association*, Vol. 284, No. 9 (6 September 2000), Appendix II, pp. 1159-1172.

⁹ Allen Dobson, and others, *Financial Performance of Academic Health Center Hospitals, 1994-2000*, Commonwealth Fund, September 2002, www.cmf.org.

¹⁰ Source: 1985 – 1998: Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2

(March - April 2001), pp. 136-147, exhibit 1, using unpublished data from the Office of the Actuary, Health Care Financing Administration. The 2002 estimate is from Centers for Medicare and Medicaid Services, *Health Care Industry Market Update: Acute Hospitals, Vol. II*, Washington: CMS, 29 April 2002, Appendix: Medicare Payment Systems, p. 4.

¹¹ James A. Reuter, *The Balanced Budget Act of 1997: Implications for Graduate Medical Education*, Washington: Institute for Health Care Research and Policy, Georgetown University, October 1997, p. 3.

¹² This total margin reflects revenue and expenses associated with both inpatient and outpatient care.

¹³ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington: The Commission, March 2002, table 2B-3, p. 60.

¹⁴ Tim M. Henderson, "Medicaid's Role in Financing Graduate Medical Education," *Health Affairs*, Vol. 19, No. 1 (January/February 2000), pp. 221-229.

¹⁵ Thomas F. Burke, "GME Funding Pools and Trust Funds in New York," *Medical Education Meets the Marketplace*, New York Academy of Science Conference, October, 1999, Part IV, conference proceedings are at www.nyas.org/books/medicaled/gme24bur.htm, accessed 30 November 2002.

¹⁶ Health Services Cost Review Commission, *HSCRC Direct Medical Education Policy: Final Adopted Recommendations*, June 2002, http://www.hscrc.state.md.us/hscrc_publications/word_docs/FinalDME.doc, accessed 30 November 2002.

¹⁷ 1 July 2001 Census Bureau estimates, <http://quickfacts.census.gov/qfd/states/36000.html>, accessed 30 November 2002.

¹⁸ The question here apparently concerns the denominator. Both Burke and American Hospital Association data report some 15,000 residents in New York State. According to federal data, there were 97,987 residents in the U.S. in 1999. See Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-158, exhibit 1, using unpublished data from the Office of the Actuary, Health Care Financing Administration. But the American Hospital Association's survey of hospitals reported only 77,411 medical and dental trainees in hospitals in 2000; of these, 14,893 were in New York State. See American Hospital Association, *Hospital Statistics, 2002 Edition*, Chicago: Health Forum, 2002. The federal data may well count individuals, not FTEs.

¹⁹ Thomas F. Burke, "GME Funding Pools and Trust Funds in New York," *Medical Education Meets the Marketplace*, New York Academy of Science Conference, October, 1999, Part IV, conference proceedings are at www.nyas.org/books/medicaled/gme24bur.htm, accessed 30 November 2002.

²⁰ Council on Graduate Medical Education, *Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment*, December 2000, pp. 37-38, www.cogme.gov.

²¹ American Association of Medical Colleges, *Medical Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know*, www.aamc.org, accessed 5 November 2002.

²² Brian Biles, "Changes in Medicare Payments to Academic Health Centers Help Level the Playing Field," Commonwealth Fund Briefing Note, 1997, www.cmwf.org/programs/taskforc/reut249b.asp, citing data from James A. Reuter, *The Balanced Budget Act of 1997: Implications for Graduate Medical Education*, 1997, www.cmwf.org/programs/taskforc/Reute249.asp, accessed 29 November 2002.

²³ Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-147.

²⁴ James A. Reuter, *The Balanced Budget Act of 1997: Implications for Graduate Medical Education*, Washington: Institute for Health Care Research and Policy, Georgetown University, October 1997, p. 9.

²⁵ This was the case in H.R. 4954, passed by U.S. House in June 2002 as the "Medicare Modernization and Prescription Drug Act of 2002." The budget proposed by President Bush for FY 2003 also would continue the freeze. American Association of Medical Colleges, *Current DGME Proposals*, www.aamc.org/advocacy/library/gme/gme0010.htm, accessed 5 November 2002.

²⁶ American Association of Medical Colleges, *Current DGME Proposals*, www.aamc.org/advocacy/library/gme/gme0010.htm, accessed 5 November 2002.

²⁷ See also Newhouse and Wilensky, who note that "every payer we know of has chosen to pay teaching hospitals higher rates (per case or per day) because of their higher costs. It seems obvious that we want to preserve the capabilities that are found in teaching hospitals." Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-147, at 143-144.

²⁸ House Ways and Means Committee Report No. 98-25 (4 March 1983) and Senate Finance Committee Report No. 98-23 (11 March 1983).

²⁹ Congressional Budget Office, *Medicare and Graduate Medical Education*, Washington: CBO, September 1995, p. 10.

³⁰ American Association of Medical Colleges, *Medicare Indirect Medical Education (IME) Payments*, www.aamc.org/advocacy/library/gme/gme0002.htm, accessed 5 November 2002.

³¹ Secretary of Health and Human Services, *Hospital Prospective Payment for Medicare: A Report to Congress*, December 1982, pp. 48-49. See Julian Pettengill and James

Vertrees, "Reliability and Validity Hospital Case-mix Measurement," *Health Care Financing Review*, Vol. 4, No. 2 (December 1982), pp. 101-128, at p. 114.

³² American Association of Medical Colleges, *Medicare Indirect Medical Education (IME) Payments*, www.aamc.org/advocacy/library/gme/gme0002.htm, accessed 5 November 2002.

³³ Federal fiscal year 1999, for example, runs from 1 October 1998 through 30 September 1999. A fiscal year is denominated by the 1 January date that is included in the year. For example, FY 1999 contains 1 January 1999.

³⁴ See Scott Hensley "Teaching Hospitals Lobby for Cash They May Not Need," [wsj.com](http://www.wsj.com), 26 November 2002.

³⁵ American Association of Medical Colleges, *Prevent Further Cuts to Medicare Teaching Hospital Payments*, www.aamc.org/advocacy/library/teachhosp/hosp0001.htm, accessed 5 November 2002.

³⁶ Federal Register, Vol. 67, No. 148, 1 August 2002, p. 50282.

³⁷ Federal Register, Vol. 67, No. 148, 1 August 2002, p. 50283.

³⁸ Brian Biles, "Changes in Medicare Payments to Academic Health Centers Help Level the Playing Field," Commonwealth Fund Briefing Note, 1997, www.cmwf.org/programs/taskforc/reut249b.asp, citing data from James A. Reuter, *The Balanced Budget Act of 1997: Implications for Graduate Medical Education*, 1997, www.cmwf.org/programs/taskforc/Reute249.asp, accessed 29 November 2002.

³⁹ Craig Caplan, AARP Public Policy Institute, "FYI: Medicare Payments for Medical Education," August 1998, http://research.aarp.org/health/fyi_education.html

⁴⁰ James A. Reuter, *The Balanced Budget Act of 1997: Implications for Graduate Medical Education*, Washington: Institute for Health Care Research and Policy, Georgetown University, October 1997, p. vi.

⁴¹ American Association of Health Plans, *The Medicare+Choice Program: What You Need to Know*, Washington: AAHP, May 2002, p. 9, http://www.aahp.org/Content/ContentGroups/Reports_Fact_Sheets/MCH52002.pdf AAHP urges that Medicare should either include GME in the calculation of local fee-for-service rates (used in setting payments to HMOs), or cap the carve-out of GME at a national average rate to create what AAHP calls a "safety net" for HMOs.

⁴² American Association of Medical Colleges, "Medicare Disproportionate Share (DSH) Payments," <http://www.aamc.org/advocacy/library/teachhosp/hosp0003.htm>, accessed 5 December 2002.

⁴³ American Association of Medical Colleges, "Medicare Disproportionate Share (DSH) Payments," <http://www.aamc.org/advocacy/library/teachhosp/hosp0003.htm>, accessed 5 December 2002.

⁴⁴ See, for example, Alan Sager and Deborah Socolar, *Many Massachusetts Hospitals Have Financial Problems, and These Must Be Addressed, but an Across-the-board Medicaid Rate Increase Is Not an Effective Solution*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 18 December 2000.

⁴⁵ One extreme outlier on efficiency was removed from this analysis.

⁴⁶ Scott Hensley "Teaching Hospitals Lobby for Cash They May Not Need," [wsj.com](http://www.wsj.com), 26 November 2002. According to the AAMC, these are data from the Medicare Payment Advisory Commission. See American Association of Medical Colleges, *Prevent Further Cuts to Medicare Teaching Hospital Payments*, www.aamc.org/advocacy/library/teachhosp/hosp0001.htm, accessed 5 November 2002.

⁴⁷ Calculated from data reported in American Hospital Association, *AHA Hospital Statistics, 1991-92 Edition*, Chicago: The Association, 1991, Tables 5A and 11.

⁴⁸ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington: The Commission, March 2000, p. 157.

⁴⁹ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington: The Commission, March 2000, p. 157.

⁵⁰ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Washington: The Commission, March 2000, p. 157.

⁵¹ Craig Lisk, Presentation on indirect medical education payments above the costs of teaching, Medicare Payment Advisory Commission meeting, Washington, D.C., 16 January 2002.

⁵² "Hospital Advocates Focus Strategy on Post-election Provider Payment Relief," *AHA News* 21 October 2002.

⁵³ American Association of Medical Colleges, *AAMC Summary and Analysis -- Federal Fiscal Year 2003 Medicare Inpatient PPS Final Rule: Provisions of Interest to the Academic Medical Community*, August 2002, www.aamc.org

⁵⁴ See Congressional Budget Office, *Medicare and Graduate Medical Education*, Washington: CBO, September 1995, pp. 40-41.

⁵⁵ Medicare Payment Advisory Commission, *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, Washington: The Commission, August 1999, p. xii.

⁵⁶ Scott Hensley, "Teaching Hospitals Lobby for Cash They May Not Need," *The Wall Street Journal*, 26 November 2002.

⁵⁷ Scott Hensley, "Teaching Hospitals Lobby for Cash They May Not Need," *The Wall Street Journal*, 26 November 2002.

⁵⁸ Craig Lisk, Presentation on indirect medical education payments above the costs of teaching, Medicare Payment Advisory Commission meeting, Washington, D.C., 16 January 2002.

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⁶⁰ Robert Dickler, Council of Teaching Hospitals, American Association of Medical Colleges, in Council on Graduate Medical Education. *Proceedings of the GME Financing Stakeholders Meeting, April 11, 2001 -- Public Response to COGME's 15th Report*, September 2001, http://www.cogme.gov/gme_finan_mtg.pdf, p. 19-22.

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⁷³ ACP-ASIM, *Physician Workforce and Graduate Medical Education in the United States of America* (statement of principles), 27 October 2000, http://www.acponline.org/hpp/pospaper/med_training.htm

⁷⁴ The brief description of elements of the two bills presented here rests heavily on AAMC, “‘All-Payer’ GME Trust Fund Legislation,” www.aamc.org/advocacy/library/gme/gme0011.htm

⁷⁵ Cited, for example, in Rep. Benjamin L. Cardin, “Introduction of the All-Payer Graduate Medical Education Act of 2001,” *Congressional Record*, 107th Congress, p. E1115, 14 June 2001, <http://thomas.loc.gov>

⁷⁶ Jay Greene, “Bill proposes new way to fund medical education,” *American Medical News*, 14 May 2001, http://www.ama-assn.org/sci-pubs/amnews/pick_01/qvsd0514.htm

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⁷⁸ American Medical Student Association, June 1999 letter to members of the Senate Finance Committee in support of Sen. Moynihan’s S. 210, www.amsa.org/hp/fc.cfm, accessed 26 November 2002.

⁷⁹ Council on Graduate Medical Education, *Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment*, December 2000, p. 7, www.cogme.gov.

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⁸¹ All cited by Rep. Benjamin L. Cardin, "Introduction of the All-Payer Graduate Medical Education Act of 2001," Congressional Record, 107th Congress, p. E1115, 14 June 2001, <http://thomas.loc.gov>

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⁸³ We appreciate this observation from a Congressional staffer.

⁸⁴ One recent comparison mentioned that one HMO paid Massachusetts General Hospital twice as much for routine deliveries as it paid a community hospital in the region.

⁸⁵ This discussion melds two documents, Medicare Payment Advisory Commission, *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, Washington: The Commission, August 1999; Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-147.

⁸⁶ Medicare Payment Advisory Commission, *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, Washington: The Commission, August 1999, p. xii.

⁸⁷ Council on Graduate Medical Education, *Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment*, December 2000, p. 62-63, www.cogme.gov. David N. Sundwall, "Another Alternative for Financing Graduate Medical Education," *Health Affairs*, Vol. 20, No. 2 (March-April 2001), pp. 156-158.

⁸⁸ Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-147.

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⁹⁰ Council on Graduate Medical Education, *Fifteenth Report: Financing Graduate Medical Education in a Changing Health Care Environment*, December 2000, p. 62-63, www.cogme.gov.

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⁹⁴ David N. Sundwall, "Another Alternative for Financing Graduate Medical Education," *Health Affairs*, Vol. 20, No. 2 (March-April 2001), pp. 156-158.

⁹⁵ "Hospital Advocates Focus Strategy on Post-election Provider Payment Relief," *AHA News* 21 October 2002.

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⁹⁷ Stephen Heffler, Sheila Smith, Greg Won, and others, "Health Spending Projections for 2001-2011: The Latest Outlook," *Health Affairs*, Vol. 21, No. 2 (March/April 2002), pp. 207-218, exhibit 1.

⁹⁸ Elizabeth C. Feil, H. Gilbert Welch, and Elliott S. Fisher, "Why Estimates of Physician Supply and Requirements Disagree," *Journal of the American Medical Association*, Vol. 269, No. 20 (26 May 1993), pp. 2659-2663.

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¹⁰¹ Source: Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, Vol. 20, No. 2 (March - April 2001), pp. 136-147, exhibit 1, citing Physician Payment Assessment Commission, *Annual Report, 1997*, Washington: The Commission, 1997, p. 352; and *JAMA* GME reports.

¹⁰² Just do the arithmetic.

¹⁰³ To be supplied.

¹⁰⁴ Alan Sager and Deborah Socolar, *Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the Public*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 20 May 1999, submitted as testimony on H. 781, Health Care Committee, Massachusetts General Court.