

**THE BALANCED BUDGET ACT OF 1997:  
IMPLICATIONS FOR  
GRADUATE MEDICAL EDUCATION**

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## **EXECUTIVE SUMMARY**

The Balanced Budget Act (BBA) of 1997 has significant implications for Medicare's support for graduate medical education (GME). The federal government spends more than \$7 billion annually to subsidize the training of physicians and nurses. In 1997 alone, Medicare will pay teaching hospitals some \$6.8 billion for their intern and residency programs. Given the level of support, any marked changes in Medicare policy will have a major effect on these programs, the institutions that conduct them, and the makeup of the physician work force.

That care in teaching hospitals is costlier than similar care elsewhere is commonly accepted. Costs related to the hospitals' training mission are partly responsible. Academic health centers (AHCs)—teaching hospitals with close affiliations with medical schools—and other teaching hospitals have long used patient care revenues to finance much of this mission. Traditionally, they have covered these expenses by charging private insurers more than the actual cost of care.

But that picture is changing. In today's increasingly competitive health care marketplace, health maintenance organizations and other types of managed care plans are aggressively pursuing lower payment rates and directing their enrollees to non-teaching, lower-cost community hospitals. The higher expenses of AHCs and other teaching hospitals put them at a competitive disadvantage in negotiations with managed care plans. Consequently, they have been losing market share for managed care patients.

So that these hospitals may continue to provide training for the next generation of physicians, many observers have suggested that support for this activity should be separated from patient care revenues. By providing a stable source of funding, this change should permit teaching hospitals to compete on a level playing field with their non-teaching counterparts.

The Balanced Budget Act helps to do just that, phasing out Medicare support for GME from premiums paid to managed care plans and paying it directly to teaching hospitals that care for Medicare managed care patients. This policy could be a model for financing graduate medical education that could be replicated across all types of insurers.

Another major concern addressed in the BBA is Medicare's influence over the numbers and types of physicians being trained. Despite a broad consensus that there are too many physicians in general and too many specialists in particular, Medicare support for GME has remained open-ended. By creating economic incentives for hospitals to expand their training programs, this policy has been a major contributor to oversupply in the physician work force.

The BBA includes amendments that will change these incentives. One caps the number of residents for whom Medicare will provide support. Another creates a system of incentive payments that will encourage teaching hospitals to downsize their training programs.

Finally, the BBA includes various savings provisions that will reduce payments to hospitals. In some cases, these provisions are focused directly on Medicare's subsidies to teaching hospitals. These include reductions in the indirect medical education adjustment (IME) (\$5.6 billion over five years) and elimination of the disproportionate share and IME adjustments on outlier cases (\$2.2 billion over five years). While partially offset by the amounts carved out of the premiums Medicare pays to managed care plans (\$4 billion over five years), the net effect is to reduce the subsidies that teaching hospitals receive from Medicare for their training activities.

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

## **1. INTRODUCTION**

The Balanced Budget Act (BBA) of 1997 significantly changes the Medicare program's support for graduate medical education (GME). Each year, the federal government spends more than \$7 billion to subsidize the training of physicians and nurses. The vast majority of these funds (some \$6.8 billion in 1997) are paid to teaching hospitals by Medicare for direct and indirect costs associated with their intern and resident training programs. Given the size of these contributions, any significant changes in Medicare policy will markedly affect these programs, the institutions that provide them, and the composition of the physician work force.

Over the past five years, Republicans and Democrats alike have advanced various proposals to reform Medicare's GME payments. The new law, passed on July 30, contains the most far-reaching reforms since Medicare's prospective payment system (PPS) replaced cost-based hospital reimbursement in 1983.

This brief discusses Medicare's existing payment policies for graduate medical education and issues related to them. It summarizes key features of the Balanced Budget Act that will affect Medicare support, ending with an exploration of the implications of these changes for teaching hospitals.

## **2. MEDICARE'S PAYMENT METHOD FOR MEDICAL EDUCATION**

That care in teaching hospitals is costlier than similar care in non-teaching facilities is commonly accepted. While the reasons are not well understood, these costs are usually attributed to several factors. One is the higher number of tests that interns and residents order and other inefficiencies related to their inexperience. Another is that patients in these hospitals are likelier to be sicker than those in non-teaching hospitals. Other reasons are the need for these institutions to be forerunners in technology and research, their location (often in the inner city), and the greater amounts of uncompensated care they provide.

Since its inception, Medicare generally has paid its share of the additional costs associated with training interns and residents in hospitals. Before 1984, this was part of its retrospective, cost-based reimbursement system. Expenses related to these training programs simply were part of Medicare's allowable costs. The program then paid its share.

The prospective payment system became effective on October 1, 1983. Under PPS, payments are made to hospitals for each Medicare discharge. Teaching hospitals also get two other types of payments for that help support their role in medical education. One is for the direct medical education costs (DME) and the other for the indirect medical education costs (IME). The DME payments are for Medicare's share of expenses directly related to a hospital's intern and resident training programs. These payments are based on a hospital-

specific, per-resident amount. The IME adjustment increases the amounts paid per discharge. It is intended to account for the relatively higher costs of patient care in teaching hospitals.

### **Direct Medical Education Adjustment**

Under PPS, the payment a hospital gets for the direct costs of graduate medical education depend on several variables. For each hospital, Medicare has a per-resident amount. Calculated in a base year and then updated to the current one, this amount reflects all of a hospital's direct costs of approved GME programs. Direct costs include salaries and fringe benefits for interns, residents, and teaching physicians, along with other costs like classroom and laboratory space that are directly related to the training activity.

For most hospitals, the base year was 1984. In general, the per-resident amount is increased each year by the annual percentage change in the consumer price index.<sup>1</sup> Medicare's share of the per-resident amount is that percentage of total inpatient bed days attributable to beneficiaries who are not enrolled in a Medicare managed care plan.

Each hospital's payment is thus the product of the per-resident amount, Medicare's share, and the weighted average number of full-time equivalent (FTE) residents in approved training programs during the year. Various special rules relate to calculating the number of FTE residents.

First, Medicare uses a concept called the initial residency period, which is the minimum amount of formal training needed to satisfy requirements for a specialty, as stipulated by the Accreditation Council of Residency Training Programs. (This cannot exceed five years.) During that period, residents receive a weight of 1.0; thereafter, they are assigned a weight of 0.5. Up to two years in geriatric or preventive medicine residencies and fellowships are weighted as if trainees were in the initial residency period, but do not count against the time limit.

Second, the time residents spend in outpatient settings counts toward the number of FTE residents a hospital has, so long as the institution incurs all or most of its training costs in such settings. Third, in calculating the number of FTE residents, foreign medical school graduates—whether or not they are U.S. citizens—are treated similarly to graduates of U.S. medical schools, provided they have passed the Foreign Medical Graduate Examination in the Medical Sciences.

### **Indirect Medical Education Adjustment**

The indirect medical education adjustment is a percentage add-on to the amount Medicare would otherwise pay the hospital for each Medicare patient under PPS. This adjustment is

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<sup>1</sup> The Omnibus Budget Reconciliation Act of 1993 provided that per-resident amounts would not be updated in 1994 or 1995, except those for residents in primary care and obstetrics and gynecology.

intended to increase payments to teaching hospitals to reflect their higher costs. The actual percentage add-on is determined using a specific mathematical formula:

$$\text{IME} = 1.89 \times \{ [1 + (\text{FTE Residents}/\text{Number of Beds})]^{0.405} - 1 \}$$

Under this formula, the IME adjustment rises as the hospital's ratio of interns and residents to number of beds goes up.<sup>2</sup> In other words, a hospital receives 7.7 percent more for each 10 percentage point increase in the ratio of interns and residents to beds. However, the adjustment is nonlinear; a 10 percentage point increase in the ratio has a greater impact on the payment adjustment for hospitals with a low ratio than for those whose ratio is high.

Under PPS, hospitals may also receive special payments for outliers—cases with unusually high costs or long stays. Before passage of the Balanced Budget Act, outlier payments were also increased using the IME adjustment.

### **Importance of Medicare DME and IME Payments**

DME and IME payments constitute a substantial share of overall Medicare support to major teaching hospitals and academic health centers. Indeed, these payments accounted for nearly a third of Medicare operating payments to academic health centers in 1994.<sup>3</sup> Nearly 30 percent of the total revenues of AHC hospitals comes from Medicare, with the DME and IME payment adjustments representing about 10 percent of that amount.

Together, DME and IME payments reached \$6.8 billion in fiscal year 1997, with IME accounting for about two-thirds (Table). Most of these dollars went to large hospitals in major metropolitan areas that treat significant numbers of the poor. (These are called disproportionate share hospitals.)

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<sup>2</sup> Note that in determining the IME payment adjustment, the number of FTE residents is not subject to the same limitations as in setting the DME adjustment. In particular, the value for a resident who is beyond the initial residency period is not halved.

<sup>3</sup> James A. Reuter, *The Financing of Academic Health Centers: A Chart Book* (New York: The Commonwealth Fund, August 1997), p. 18.

**Table: Distribution of Medicare Payments for Graduate Medical Education,  
by Type and Location of Hospital, 1997**

<b>Hospital Characteristics</b>	<b>Share of DME Payments</b>	<b>Share of IME Payments</b>	<b>Share of Total GME Payments</b>
<b>Teaching Status</b>			
Major teaching hospitals (IRB>0.25)	68.4%	69.5%	69.2%
Other teaching hospitals	31.5%	30.5%	30.8%
<b>Disproportionate Share Status</b>			
Disproportionate share hospitals in large urban areas	60.8%	56.6%	57.8%
Other disproportionate share hospitals	19.0%	20.1%	19.8%
All other hospitals	20.2%	23.2%	22.4%
<b>Hospital Ownership</b>			
Private nonprofit	82.4%	81.2%	81.5%
Public	15.5%	16.8%	16.4%
For-profit	2.1%	2.0%	2.0%
<b>Hospital Size</b>			
200 beds or less	7.6%	6.0%	6.4%
201 to 400 beds	31.9%	31.3%	31.5%
Over 400 beds	60.6%	62.7%	62.1%
<b>Urbanization</b>			
Large urban area (population>1 million)	76.1%	74.6%	75.0%
Other urban (population<1 million)	22.6%	24.0%	23.6%
Rural	1.4%	1.3%	1.4%

Note: IRB=Interns and residents to beds ratio; DME=direct medical education; IME=indirect medical education; GME=graduate medical education.

Source: Georgetown University, analysis of HCFA 1997 Impact File and unpublished data from the Hospital Cost Report Information System, HCFA.

### **3. ISSUES RELATED TO SUPPORT FOR GRADUATE MEDICAL EDUCATION**

Among the issues related to ongoing support for graduate medical education are market competition, the growth of Medicare managed care and how the program pays for it, and the composition of tomorrow's physician work force.

#### **Competition and Support for Graduate Medical Education**

Historically, academic health centers—hospitals with close affiliations with medical schools—and other teaching hospitals have used patient care revenues to finance much of their teaching and research activity. Medicare (and in some states, Medicaid) is among the few payers that make specific payments to support graduate medical education. Traditionally, teaching hospitals have covered the rest of these expenses by charging private insurers more than the actual cost of care. The Prospective Payment Assessment Commission (ProPAC)

found that, in 1995, hospitals charged private insurers almost 24 percent more than actual costs.<sup>4</sup>

More recently, however, health maintenance organizations (HMOs) and other forms of managed care have become more aggressive in efforts to establish provider networks, negotiate discounted payment rates, and direct their enrollees to less costly, in-network providers.

With expenses running between 20 percent and 30 percent higher than those at their non-teaching community hospital competitors, AHCs and other teaching hospitals are significantly disadvantaged in these negotiations. In 1997 alone, their social missions—missions centering on research, education and training, and specialized care—added more than \$18 billion to the price tag for patient care.<sup>5</sup> Consequently, many have lost market share for private managed care patients to their community hospital counterparts. This is supported by a study of hospital discharge patterns, which found that AHC hospitals' share of the managed care market was only 80 percent that of their share of the privately insured market. By contrast, large non-teaching hospitals had a 10 percent greater share of the managed care market than their share of the market for traditionally insured patients.<sup>6</sup>

Teaching hospitals and AHCs have responded to these competitive pressures by curbing their costs. A recent study found that, during an eight-year period, annual cost growth for AHCs in areas with high HMO penetration was 1.7 percentage points below that of areas where HMO penetration was low.<sup>7</sup> Thanks to the falloff in cost growth, these hospitals increased their overall margins despite slower revenue growth. During this same period, however, non-teaching hospitals drove down their costs at an even faster rate. Thus, while AHCs and other teaching hospitals have reined in their costs, they may not have materially improved their competitive position in the market for managed care patients.

Many observers believe that teaching hospitals will never be able to compete with community hospitals on price alone. The presence of interns and residents is thought to introduce inefficiencies that can never be entirely eliminated. Academic health centers have the additional burdens and inefficiencies related to their roles in medical student training, research, and technology development and dissemination.

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<sup>4</sup> Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington, D.C.: Prospective Payment Assessment Commission, June 1997), p. 85.

<sup>5</sup> The Commonwealth Task Force on Academic Health Centers, *Leveling the Playing Field: Financing the Missions of Academic Health Centers* (New York: The Commonwealth Fund, May 1997), p. 12.

<sup>6</sup> *Ibid.*, p. 20.

<sup>7</sup> Jack Hadley and Darrell J. Gaskin, "Policy Brief: Preliminary Evidence on the Impact of HMO Enrollment in Academic Health Centers," unpublished manuscript (Washington, D.C.: Institute for Health Care Research and Policy, December 1995), p. 8.

If AHCs cannot retain their share of privately insured patients, financial pressures may force them to curtail their training and research missions. That this is so is already becoming apparent. For example, AHCs in areas with high HMO penetration have curbed spending on graduate medical education. Between 1990 and 1993, for instance, GME spending grew by only 21 percent in such areas, compared with 36 percent where there was less competition from HMOs.<sup>8</sup>

There is also some evidence that AHCs in highly competitive areas are restricting their research activities. Between 1990 and 1995, research grants from the National Institutes of Health to medical schools in areas with low or moderate managed care penetration rose in constant dollars; awards to the thirteen schools in areas with high managed care penetration declined.<sup>9</sup>

Despite debate over how much training and research should be produced, there is growing recognition that AHCs will not be able to continue subsidizing their social missions from patient care revenues and, simultaneously, compete effectively in the marketplace. As a consequence, many have suggested that support for these missions be separated from patient care revenues and paid directly to the institutions themselves.

One approach to accomplish this is an “all-payer” financing pool, a feature in legislative proposals of both parties and the centerpiece of a recently released report by the Commonwealth Fund Task Force on Academic Health Centers. That report recommended establishing a separate trust fund to finance the patient care-related costs of these missions, thereby separating education and research from patient care revenues.<sup>10</sup> Relieved of these costs, AHCs and other teaching hospitals would, the task force reasoned, be better-positioned to compete in the managed care market on the basis of price, yet still pursue their vital missions.

The proposed trust fund would be financed through a combination of contributions from Medicare, Medicaid, a health insurance premium tax, and general revenues. The task force suggested that, for 1997, a pool of \$15 billion would suffice.

### **Medicare Managed Care Payments and Support for Graduate Medical Education**

The general concerns about the financing of the social missions of AHCs and other teaching hospitals have focused primarily on change occurring in the private markets for health

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<sup>8</sup> *Ibid.*, p. 16.

<sup>9</sup> Ernest Moy, *et al.*, “Relationship Between National Institutes of Health Research Awards to U.S. Medical Schools and Managed Care Market Penetration,” *Journal of the American Medical Association* 278(3):217-21, July 16, 1997.

<sup>10</sup> The Commonwealth Task Force on Academic Health Centers, *Leveling the Playing Field: Financing the Missions of Academic Health Centers* (New York: The Commonwealth Fund, May 1997), p. 31.

insurance and health care services. However, a very similar situation exists with respect to Medicare managed care plans.

For most of the elderly, who receive benefits through traditional, fee-for-service plans, hospitals get explicit subsidies for graduate medical education through Medicare's DME and IME payments. Hospitals have not received these subsidies for Medicare patients enrolled in managed care plans, or so-called risk contracting HMOs. As for privately insured patients, teaching hospitals must negotiate with Medicare HMOs rates that are adequate to cover their costs, including the patient care-related costs associated with their teaching missions. The higher costs of care in these institutions places them at a disadvantage in these negotiations, relative to their non-teaching community hospital competitors.

Until recently, the number of beneficiaries enrolled in HMOs has been relatively small—about 11 percent of the Medicare population in 1996. However, even prior to enactment of the BBA, the number of Medicare beneficiaries in these types of plans was expected to more than double by 2003. As Medicare patients represent a substantial share of all patients in teaching hospitals, this shift may have serious consequences for the financing of graduate medical education

Before passage of the Balanced Budget Act, Medicare made capitation payments (preset, per-person monthly amounts) to HMOs and other risk contracting plans. In general terms, the program pays HMOs 95 percent of an amount called the adjusted average per capita cost (AAPCC). This amount is intended to reflect the expenses that Medicare would incur for a beneficiary had that person not enrolled in the HMO.

In calculating the AAPCC, the estimate includes the amounts paid to teaching hospitals for the direct and indirect costs of GME. Thus, the AAPCC—and therefore the per capita payments to HMOs—are higher in areas with teaching hospitals. It is estimated that in 1997, Medicare's capitation payments are nearly \$700 million higher due to the inclusion of IME and DME in the calculation of payments.<sup>11</sup> This amount will continue to increase in proportion to the growth in Medicare enrollment in managed care plans.

As in the private sector, it has been suggested that Medicare's support for teaching should not be passed through managed care plans; that is, these payments should be excluded from the capitation amounts. Instead, they should be paid directly to teaching hospitals that serve Medicare managed care patients. Under this approach, these facilities would be more price-competitive with their non-teaching counterparts in negotiations with managed care plans.

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<sup>11</sup> *Ibid.*, p. 37.

## Issues Related to the Physician Work Force

Observers generally agree that the country's supply and specialty mix of physicians are increasingly unbalanced relative to needs.<sup>12</sup> At issue are whether there are too many doctors in general, and too many specialists in particular.

Despite pockets of physician shortages related to geographic maldistribution, the current physician to population ratio is considered adequate to meet the nation's needs. Nonetheless, this ratio continues to grow for an array of reasons. Among these are slower population growth, lingering results from policies in the 1970s that expanded the size and number of medical schools, and high immigration rates of foreign-trained physicians.

As for specialists, it is widely held that there is an oversupply and, further, that heavy reliance on their care drives up costs without significantly enhancing quality. Compared with traditional, fee-for-service sectors, staff model HMOs make much greater use of primary care physicians. With growing enrollment in all types of managed care plans, primary care doctors will play an ever-greater role in providing patient care, further increasing the relative surplus of specialists.

While many factors contribute to the growing physician surplus, Medicare's open-ended subsidies for graduate medical education are regarded as a major culprit. The program does not limit the number of FTE residents, either within a hospital or in aggregate, for which it will pay. Consequently, if the marginal cost of adding a resident is less than the overall subsidy, a hospital has a strong incentive to create more residency positions.

The combination of Medicare's IME and DME subsidies per resident can be substantial, according to the Congressional Budget Office (CBO). Although the exact figure depends on factors like the interns and residents to beds ratio, the marginal additional subsidy a hospital gets from Medicare for adding a single resident can exceed \$70,000 per year. The average hospital-specific amount per resident was about \$54,000 in 1993. The average salary per resident in 1993-94 ranged from \$29,632 to \$37,363, depending on the year of training.<sup>13</sup>

The hefty size of Medicare subsidies has prompted many proposals for payment reform that would give hospitals economic incentives to trim their residency programs and to maintain—or increase—the number of physicians being trained in primary care specialties. The Council on Graduate Medical Education, for instance, in 1997 called for capping hospital-specific FTE figures used to calculate Medicare GME payments and for eliminating such payments for new “exchange visitor” residents.

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<sup>12</sup> See, for example, Council on Graduate Medical Education, *Eighth Report, Patient Care Physician Supply and Requirements: Testing COGME Recommendations* (Washington, D.C.: Council on Graduate Medical Education, July 1996).

<sup>13</sup> Association of American Medical Colleges, *AAMC Data Book: Statistical Information Related to Medical Education* (Washington, D.C.: Association of American Medical Colleges, 1994), Table G1.

## **Appropriateness of Medicare GME Payments**

Medicare's open-ended support for graduate medical education is not the only issue of concern in the payment area. Another is whether these payments are appropriate, given their wide variation.

As noted earlier, the DME payment is based on a hospital-specific rate per FTE resident using 1984 as the base year. These amounts vary markedly: Of 1,100 teaching hospitals, 65 have an amount above \$100,000 annually; for 275, the amount is less than \$38,000. Why this is the case is unclear, since the differences appear to be unrelated to cost of living or salaries and fringe benefits. Some believe the explanation lies in hospital accounting practices during 1984. Although there have been proposals that would narrow these differences, none have been enacted.

As for the IME adjustment, it is based on a regression analysis dating from 1984. The estimate of the model's parameters never suggested an adjustment constant as large as the 1.89 value used in the current formula. Rather, this figure was negotiated upward from the estimated value due to concerns regarding the initial implementation and impact of PPS. It was feared that payments to teaching hospitals would be too low, and so the adjustment was increased to provide an extra cushion. The adjustment was subsequently reduced to its current level in 1986 and 1987, when data for the period following PPS implementation became available.

ProPAC's most recent estimate of the regression model suggests that an IME adjustment based strictly on costs would lower the current adjustment from an increase of about 7.7 percent for each 10 percentage point change in the interns and residents to beds ratio to an increase of 4.1 percentage points. ProPAC proposed a modest reduction for 1998, recommending that additional change be slow and monitored carefully to ensure that beneficiaries continue to have access to care at teaching hospitals.<sup>14</sup>

## **4. PROVISIONS OF THE BALANCED BUDGET ACT OF 1997**

Provisions in the Balanced Budget Act of 1997 make significant reforms in the subsidies teaching hospitals get from Medicare. A key change is that the law separates payments for graduate medical education from those for patient care. IME and DME payments are phased out of Medicare's capitation payments to managed care plans. Instead, Medicare will make these payments directly to teaching hospitals that treat beneficiaries in managed care arrangements. These provisions could be a model for future expansion of this concept to the private sector to ensure support for GME. Most importantly, under this approach, teaching hospitals will be able to compete for Medicare managed care patients on a level playing field.

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<sup>14</sup> Prospective Payment Assessment Commission, *Report and Recommendations to Congress, March 1, 1997* (Washington, D.C.: Prospective Payment Assessment Commission, March 1997), pp. 28-29.

In addition, the BBA includes provisions that stem Medicare's open-ended support for GME, establishing new incentives for downsizing residency training programs while retaining support for primary care specialties.

### **Payment Changes for Beneficiaries in Managed Care**

The Balanced Budget Act establishes new options for Medicare beneficiaries to enroll in managed care plans. To be called Medicare+Choice plans, these include traditional HMOs like those in Medicare's risk contracting program, preferred provider organizations, provider-sponsored organizations, and combinations of medical savings accounts and high-deductible insurance plans.

Capitation payments to these plans will be based on a modified version of the AAPCC. These changes have several objectives. One is to raise capitation amounts in areas that have had, under the current policy, relatively low premiums. This is intended to attract new managed care plans to geographic areas they previously had ignored. However, these increases will be offset by lowering premiums in areas where they have been relatively high.

Determining the long-term net effect of premium changes on beneficiary enrollment in managed care is difficult. When CBO estimated the costs of the new law, it did not expect these changes to have a major effect on the growth of Medicare managed care plans. Under previously existing policies, enrollment was expected to rise to 23 percent of the Medicare population by 2002, compared with 27 percent under the Balanced Budget Act.

As for graduate medical education, the BBA sets an important precedent by making payments directly to the teaching institutions that serve Medicare managed care patients, rather than to the plans themselves. This approach is consistent with the recommendations of groups like the Commonwealth Fund Task Force on Academic Health Centers. The change will permit teaching hospitals to compete more fairly for market share and, at the same time, benefit from direct support for their teaching mission.

The shift will occur over a five-year transition period, ending in 2002. CBO estimates that in 2002, this provision will remove \$1.6 billion from the capitation amounts paid to health plans. Instead, that amount will go directly to teaching hospitals for care provided to patients enrolled in managed care plans.

### **Medicare GME Payments and the Physician Work Force**

Several provisions in the new law will make Medicare's GME payments more in concert with long-range objectives of slowing the growth rate of the physician work force and maintaining—or even increasing—the number of doctors opting for primary care specialties.

**Freeze in FTE Counts.** The BBA eliminates Medicare’s open-ended support for graduate medical education. On a hospital-specific basis, this provision initially caps the number of FTE residents used to calculate DME and IME payments at the most recent cost reporting period before December 31, 1997. In subsequent years, the cap will be recomputed using a three-year rolling average. The Secretary of the U.S. Department of Health and Human Services has limited authority to make exceptions to this cap, as, for example, in the case of a new training program. However, the Secretary cannot authorize exceptions that expand the total number FTE residents nationally. In other words, increases in the allowed number of FTEs in new programs must be offset by decreases in others.

**Incentive Payments to Hospitals to Reduce the Numbers of Trainees.** Other provisions of the BBA give hospitals economic incentives to downsize their residency training programs. Hospitals that qualify will submit a plan to reduce the number of their trainees by 20 percent or by 25 percent, depending on the existing size of their program. They are, however, required to maintain their prior number of primary care trainees.

The incentive payments will equal a declining percentage of the difference between the payments for GME, given the actual number of residents, and what the hospital would have received if it had trimmed its training program by 5 percent. Hospitals that train more residents than their plans proposed, or that reduce the number of those in primary care, must repay all of their incentive payment.

CBO has estimated that the combined effects of the cap on FTEs and the incentive payment provisions will be a 3 percent reduction in the number of residents being trained.

**Provisions Related to Primary Care.** Under current law, Medicare DME payments can only be made to individual hospitals. As primary care training may be most appropriately conducted in non-inpatient settings, this restriction is seen as reducing support for the training of primary care physicians.

The BBA includes several provisions that will expand the types of entities eligible to receive Medicare support for the direct costs of residency training programs. It is hoped that this will redirect some funds to support primary care training. First, the legislation allows DME payments to rural health clinics, federally qualified health centers (e.g., community health centers), Medicare managed care plans (e.g., Medicare+Choice plans), and other entities the Secretary determines appropriate.

Additionally, the law provides for demonstration projects that would make DME payments to what it calls “consortia.” These groups must comprise one or more teaching hospitals, but could also include medical group practices, other outpatient facilities, rural

health clinics, federally qualified health centers, Medicare+Choice plans, and other types of health care providers.

And, finally, the legislation establishes an exception to the existing definition of the initial residency period to allow payments for certain combined residency training programs in primary care.

### **Other Provisions Related to GME Savings**

Included in the BBA are various provisions related to savings from Medicare payments for graduate medical education. These concern the formula used for the IME adjustment and the treatment of outlier cases.

**IME Payment Adjustment Formula.** Under the BBA, the formula used to derive the IME payment adjustment is modified so that payments will be lower. Together with the cap on residents, this provision will reduce IME payments by \$5.6 billion between fiscal year 1998 and fiscal year 2002. Previously, the formula provided for an adjustment of 7.7 percent for each 10 percentage point increase in the interns and residents to beds ratio. Under the BBA, this adjustment is phased down to 5.5 percentage points by the year 2000. After the phase-in is completed, IME payments to teaching hospitals will be reduced by 28.5 percent.

**Outlier Cases.** The current law increases Medicare's payment for outlier cases using the IME and disproportionate share adjustments, as noted earlier. Under the Balanced Budget Act, these payments will not be adjusted for either factor, resulting in \$2.2 billion in savings between 1998 and 2002. Since teaching hospitals receive more than half of all outlier payments (57 percent) and two-thirds of disproportionate share payments, this provision will significantly affect them. About 300 major teaching hospitals (including AHCs) will bear just over half of these reductions.

### **Recommendations on Long-Term Financing of GME**

Other provisions of the new law relate to a requirement for developing recommendations on the long-term financial stability of the Medicare program and the trust funds that support it. To formulate these, the BBA set up the National Bipartisan Commission on the Financing of Medicare. The commission is also charged with looking at alternative, broad-based funding sources for GME. In addition, its mandate includes consideration of GME funding for institutions like children's hospitals that do not now receive Medicare GME support, but that conduct approved graduate medical residency programs.

The BBA also combined ProPAC and the Physician Payment Review Commission into a new entity called the Medicare Payment Advisory Commission (MedPAC). The commission's responsibilities include providing the Congress with annual recommendations on payment policies under Medicare and the newly enacted Medicare+Choice program. In

addition, MedPAC must conduct a special study of issues related to graduate medical education, such as the methods for making GME payments and the size and composition of the physician work force. The Commission is to report on this special study to the Congress within two years.

## **5. SUMMARY AND CONCLUSIONS**

Leveling the playing field for Medicare patients, moderating growth in the physician work force and in the number of specialists, and changing how Medicare pays for its share of graduate medical education are three key areas addressed by the Balanced Budget Act of 1997.

### **Leveling the Playing Field for Medicare Patients**

Clearly, the most important aspect of the law with regard to graduate medical education is recognition of the need to establish alternative funding sources. As competitive pressures increase, managed care plans are demanding greater discounts, reducing the ability of teaching hospitals to continue the historical cross-subsidies from patient care revenues that have been used to finance teaching and research. The BBA includes a model that, as far as Medicare patients are concerned, will provide a cushion so that teaching hospitals can participate in the market on a competitive basis.

These provisions may profoundly affect negotiations between such hospitals and Medicare managed care plans. Today, they must try to obtain a price that will cover all of their expenses, including the higher patient care costs associated with their social missions. Under the new law, hospitals will participate in these negotiations knowing that, for each Medicare managed care patient, they will receive an additional payment directly from Medicare.

Even after the reductions in the IME adjustment enacted in the BBA, a hospital with a substantial teaching program will be able to offer a significant discount from what it would receive for a patient with traditional Medicare coverage. For example, for a hospital with a 0.4 ratio of interns and residents to beds (or four residents for every ten beds), this discount could be as high as 20 percent after the phase-in of these payments is complete. For academic health centers, many of which have interns and residents to beds ratios greater than 0.5, these discounts could be 25 percent or more. Given these discounts, AHCs could become aggressive participants in the market for Medicare managed care patients.

But the BBA's provisions alone will not solve the challenge of establishing a stable source of financing for the higher patient care costs of academic health centers. With Medicare accounting for only about 29 percent of their revenue, they will still have a

competitive disadvantage in other sectors of their markets. Nonetheless, the new law creates a model—and a testing ground—for a funding option that could be broadened in the future.

### **The BBA's Effect on the Physician Work Force**

The Balanced Budget Act represents the first significant attempt to use Medicare payments to support changes in the physician work force. Through economic incentives, it aims to reduce both the growth in and total number of graduate medical education training slots. At the same time, it attempts to maintain the current levels of training for primary care physicians.

It caps at 1997 levels the total number of FTE residents used to calculate Medicare DME payments. Hospitals whose programs grow larger will not get additional payments for direct or indirect medical education costs. Hospitals with shrinking training programs are eligible to participate in the incentive payment program. Even though slots in new programs might be exempted by the Secretary, nationally the total number receiving Medicare support could not increase.

The combined effect of these policies is hard to predict and will differ for each hospital, depending on its particular circumstances. Some hospitals have already indicated that, even without these new incentives, they intend to trim their training efforts. For this group, the incentive payments will simply be a windfall. For other institutions, though, the incentives may tip the balance in favor of reducing or even eliminating some training programs.

In estimating the costs and savings associated with these provisions, CBO assumed a reduction of only 3 percent in the number of residency training positions receiving Medicare funds. Given that current projections suggest the need to curb these slots by one-quarter to one-third, this is an extremely modest, albeit important, step.

### **General Support for Teaching Hospitals**

Although the BBA sets a significant precedent in the approach used to determine Medicare support for GME, teaching hospitals will continue to face significant reductions in the growth of their Medicare revenues.

For the first five years, lower payments to hospitals will account for the largest share (nearly 30 percent) of total savings to the Medicare program. For many of the BBA's provisions, such as those related to capital, teaching hospitals simply share in the overall slower growth of Medicare payments with which all hospitals will have to grapple.

The legislation also includes savings provisions that target Medicare's teaching subsidies and that fall disproportionately heavily on teaching hospitals. These include a \$5.6 billion reduction in IME subsidies and elimination of \$2.2 billion in IME and

disproportionate share payments for outliers, both to take effect over a five-year period. These dollars are partially offset by the amounts carved out from the payments to managed care plans (\$4 billion over five years). Nevertheless, the net effect is a reduction in the subsidies these hospitals will receive from Medicare for their teaching-related activities.

