



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

Medicare Payment Issues of
Interest to Teaching Hospitals

April 1992



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Interest to Teaching Hospitals**

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DIVISION OF CLINICAL SERVICES

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- o COTH Survey of Hospitals' Financial and General Operating Data*
- o COTH Executive Salary Survey**
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- o Avenues to Access: A Resource Guide to Health Care Reform
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- o GFP Practice Plan Profiles*
- o GFP Notes (newsletter published four times yearly)
- o Faculty Practice Plans: The Organization and Characteristics of Academic Medical Practice
- o Physician Payment Reform Policy Considerations

* Distributed on a confidential basis to survey participants.

** Distributed on a confidential basis to COTH member CEOs.

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MEDICARE PAYMENT ISSUES OF INTEREST TO TEACHING HOSPITALS

Introduction. As an association of medical schools, teaching hospitals and academic societies, the AAMC works with its members to set a national agenda for medical education, biomedical research and health care, and provides services at the national level that facilitate the accomplishment of their missions. A key role of the Association is to explain the special characteristics and concerns of teaching hospitals to Congress, executive branch agencies, regulatory bodies and private payers. As part of its public education and advocacy role on behalf of the nation's teaching hospitals, the AAMC monitors federal health initiatives in Medicare hospital payment policy.

The purpose of this document is to inform AAMC constituents about the policy debate surrounding several Medicare hospital payment issues of particular interest to teaching hospitals. As the federal government attempts to control the deficit and move toward some type of national health reform, these issues are likely to receive attention in the coming year. They include refinement of the Medicare Diagnosis-Related Groups (DRGs), changes in the level and calculation of the Medicare indirect medical education (IME) adjustment in the prospective payment system (PPS), and changes in Medicare direct graduate medical education payments.

Background on the Prospective Payment System. The Federal government enacted the Medicare prospective payment system (PPS) for hospital inpatient services in 1983, intending to hold down health care expenditures and to provide hospitals financial incentives to deliver services efficiently while maintaining access and quality of care. By determining in advance the amount hospitals would be paid for the care of Medicare inpatients in each of the current 492 diagnosis-related groups (DRGs), hospitals and the Federal government would also benefit from a predictable flow of Medicare payments.

The PPS balances the concept of a national average price, intended to promote efficiency, with the recognition that costs vary among hospitals, often due to factors beyond their control. These factors include location, types of patients, level of teaching activity, and share of low-income patients. All hospitals' PPS payments are adjusted by three factors: location (urban/rural); area wage differences; and the types of patients treated in a facility as determined by their classification into DRGs (case mix). Not all hospitals receive payments for outlier cases (cases of extremely long length of stay or extraordinarily high cost), or the disproportionate share (DSH) or the indirect medical education (IME) adjustments. The IME adjustment compensates teaching hospitals for the cost impact of their special missions; the DSH adjustment partially compensates hospitals for the higher costs associated with treating low-income patients.

Since the PPS departed substantially from the previous cost-based reimbursement system, its implementation was phased-in over several years. In the early years of the PPS, hospitals

were paid a blend of their hospital-specific costs and a national standard price. By Federal Fiscal Year 1988, hospitals were paid 100 percent of the national rate.

While the PPS was being implemented, many hospitals received PPS payments in excess of their PPS operating costs. Government bodies such as the Prospective Payment Assessment Commission (ProPAC) and the Inspector General of the Department of Health and Human Services issued analyses of hospital PPS margins showing that hospitals, particularly teaching hospitals, had achieved substantial margins under the PPS. The Federal government responded by limiting the annual update factor to the rate of inflation for medical goods and services (referred to as the marketbasket rate) less a legislated amount.

By removing the connection between the cost of patient care at an individual institution and its Medicare payment, the PPS changed substantially the distribution of Medicare payments among hospitals. Large disparities in hospital financial performance under the PPS resulted. Refinements to the structure of the PPS (such as updating with new data) and policy changes enacted by Congress to correct perceived inequities in PPS payments continue to affect the level and distribution of payments. Congress and the Administration have most often used budget neutral or cost-savings approaches, rather than adding new funds to the PPS, to address inequitable PPS operating margins among hospital groups.

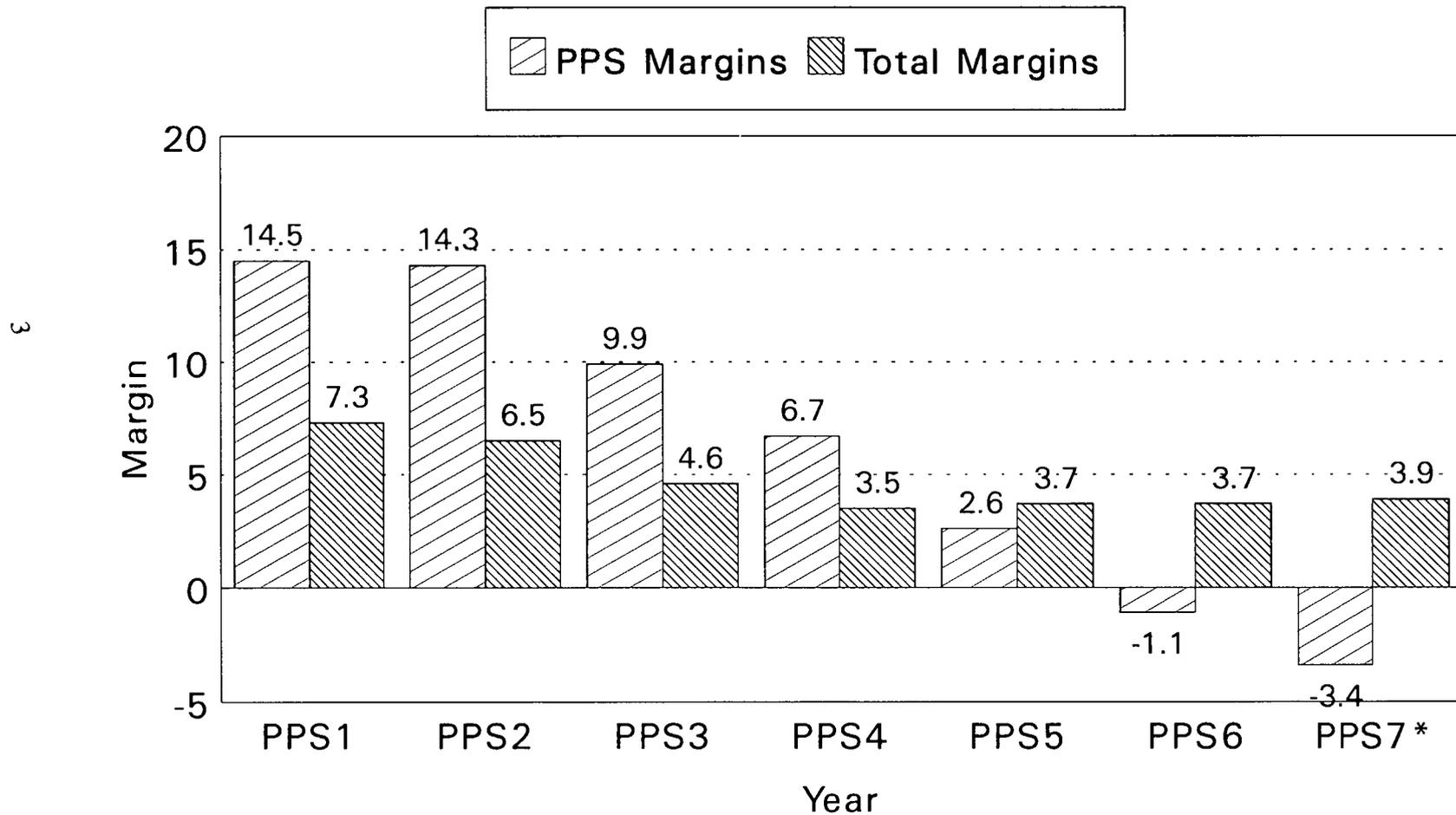
While the hospital community generally supported the implementation of the PPS, hospitals are now pitted against each other in a zero-sum world where payment system "improvements" for one group of hospitals may negatively affect the financial condition of other potentially equally vulnerable hospitals. For example, in 1989 Congress created a process that allowed hospitals to request changes in geographic classification to receive a higher basic PPS rate or a higher wage adjustment. Primarily aimed at hospitals located in rural areas, these hospitals could apply to be reclassified as urban hospitals to get the higher rates paid to facilities located in urban areas. By law, however, a change in status has to be cost-neutral; thus, extra dollars given to reclassified rural hospitals must be taken from funds earmarked for urban hospitals. For FY 1992, over 950 hospitals were approved for reclassification to areas with higher payment rates or wage indexes which will reduce payments to urban hospitals by about \$425 million.

In the meantime, hospitals' average PPS operating margins continue to decline (Figure 1). While aggregate PPS operating margins were over 14 percent in the first two years of the PPS, the average PPS margin was -3.4 percent in the seventh year of the PPS (1990). The percentage of hospitals with negative PPS operating margins has ballooned from 18 percent of hospitals in PPS-1 to over 60 percent in PPS-7.

Some in the hospital community have pointed to the decline in PPS operating margins as evidence that adequacy, not just equity, of the PPS must be addressed by Congress and the Administration. Inflation updates to the basic PPS rates have been consistently lower than the actual increases in the price of medical goods and services. Critics cite declining margins as the result of hospitals' failure to control rising costs.

Figure 1

PPS Operating and Total Margins, First Seven Years of PPS



*Data for PPS7 are preliminary.

Source: Medicare Cost Reports, calculated by ProPAC.

In the aggregate, however, hospitals' total margins have remained relatively healthy (Figure 1). The aggregate total margin is considerably higher now than it was during the 1970s. Since the fourth year of the PPS, average total margins have remained between 3.5 to 4 percent, declining from 7 percent in the first year of the PPS. Hospitals have maintained their total margins by increasing reliance on non-patient care revenues and by cost shifting to other payers. A recent ProPAC analysis found the Medicare program paid about 91 percent of its share of hospital costs on average; Medicaid paid 74 percent of its costs and private payers covered 128 percent of their costs.

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Issue: Adopting Major Refinements to the Diagnosis-Related Groups (DRG) Patient Classification System

Background. The DRG patient classification system distinguishes many important patient characteristics that are highly correlated with hospital costs, such as principal diagnosis, presence or absence of secondary diagnosis, and whether or not certain major surgical procedures were performed based on the hospital stay. However, DRGs do not distinguish severity of illness within diagnostic groups, nor do they account for many other characteristics that are likely to affect a patient's stay and costs, such as whether patients were transferred from other facilities.

As conditions, treatments and patterns of care change, the DRGs may also be changed by creating a new DRG, or by reassigning certain cases to another, more appropriate, DRG. Between 1990 and 1991, the HCFA made the most extensive modifications to the DRGs since the inception of the PPS. The objective of DRG refinement is to improve the ability of the DRGs to reflect patient resource needs and associated costs. However, there are also direct payment implications of any DRG modification. Since the overall payment impact of any changes in the DRGs must be budget neutral under current law, the primary payment impact is a different allocation of PPS payments across hospitals.

Some analysts have suggested there are two sets of DRGs available that would improve classification of patients compared to the DRGs currently used by HCFA (HCFA DRGs): the All-Patient DRGs (AP-DRGs) used by the states of New York, New Jersey and Maine and the All-Patient Refined DRGs developed at Yale University, often called the Yale DRGs. While the HCFA DRGs currently in use are highly effective in identifying patients requiring complicated technology services, e.g., coronary bypass patients, the Yale refinement focuses primarily on making better use of information about comorbidities and complications to incorporate the relative health of patients. As a consequence, the Yale refinement includes 1,190 DRGs compared to 492 DRGs in the current system.

For nearly two years, ProPAC has conducted an evaluation of the Yale DRGs. ProPAC analysts found that the Yale DRGs classified cases more accurately than either the current HCFA DRGs or the AP-DRGs.

Adoption of alternative DRG systems would affect payments because of changes in hospitals' case mix indexes and changes in the distribution of outlier payments. While overall average case mix values or aggregate PPS payments would not change, by definition, under either new system, ProPAC found changes in individual hospitals' case mix indexes would range from -6 to nearly 5 percent with the Yale DRGs, and payments for individual hospitals would change even more due to shifts in outlier payments. Under the Yale DRGs, the change in PPS payments would range from -7 to 14 percent. Adoption of the Yale DRGs would lead to much greater changes in payments within hospital groups, e.g., major teaching, than would occur between groups, e.g., major teaching/nonteaching.

To understand how members of COTH would fare under these systems, the AAMC engaged the developers of the Yale DRGs to conduct an analysis of the systems' impact on COTH members' PPS payments. Completed in November 1991, the authors concluded that on average PPS payments to COTH members would increase 0.8 percent under the Yale DRGs, while for academic medical center hospitals payments would increase 1.2 percent. The payment impact on individual COTH hospitals varied considerably under the Yale DRGs, from -6 to 10 percent. When payment impact was analyzed by hospital group, in general, hospitals located in urban areas with over one million population and with large Medicaid case loads had the largest increases in PPS payments.

Discussion. ProPAC is ambivalent about further intensive analysis of the Yale DRGs. A comprehensive evaluation of a potential package of reforms would consume a significant amount of the commission's staff time and computer resources. ProPAC has concluded that the Yale refinement would result in more accurate classification and payment for Medicare PPS cases, but that adoption of major changes in the DRGs without investigating additional issues, such as changes in outlier policy and the interaction of the IME and DSH adjustments with the patient classification system, would be inappropriate. In its March **Report to the Congress**, the commission asks hospitals for their views on the adoption of DRG refinements.

HCFA continues to evaluate potential improvements to the current DRGs. The AAMC's contractor shared the results of its study with HCFA in November 1991 and discussed improvements in the DRGs for Federal Fiscal Year 1993. HCFA will likely continue to make incremental refinements in the DRGs, incorporating some of the features of the Yale DRGs, but stopping short of adopting the entire system.

For its part, the AAMC cites the inadequacy of the current DRGs to account fully for severity of illness as one of the rationales behind the IME adjustment. Studies demonstrate that the Yale DRGs recognize patient complications and comorbidities with a greater degree of differentiation than any other DRG system. If the Yale DRGs were adopted, the IME

adjustment would certainly be reestimated because of its interaction with the classification system. The statistical estimate for the IME adjustment, the difference in costs between teaching and nonteaching hospitals, would likely fall below the current 5.7 percent statistical estimate. The current level of the IME payment adjustment is 7.7 percent. A lower statistical estimate will increase pressure to lower the level of the IME payment adjustment.

While on average PPS payments to major teaching hospitals under the Yale DRGs would increase about 1 percent, the redistributive effects of the new classification system, combined with a possibly significant reduction in the IME adjustment for all teaching hospitals, could have a severe negative impact on individual COTH members. On the other hand, the IME adjustment remains a perennial target of federal deficit reduction proposals. Some believe teaching hospitals would experience less uncertainty from year to year if severity of illness were captured in the DRGs and were paid through the case mix index.

While the Yale DRGs more accurately classify Medicare patients by accounting for severity of illness, a full analysis of the integration of the Yale DRGs into the PPS has not been conducted. The interaction of several elements of the current PPS, such as the IME adjustment and outlier policy, with the Yale DRG classification system is yet to be studied.

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Issue: Reducing the Level of the Indirect Medical Education Adjustment in the Medicare PPS for Operating Costs

Background. The IME adjustment in the PPS recognizes the higher costs faced by teaching hospitals in the treatment of Medicare patients. These higher costs are attributed to the treatment of patients with more severe or complex illnesses, provision of a broader scope and variety of services, introduction of new diagnostic and treatment services, and expenses associated with the provision of clinical education programs in the medical, nursing and allied health professions.

Under the PPS, teaching hospitals receive IME payments as determined by their individual intern and resident-to-bed ratios (IRBs) and an empirically based adjustment factor. The IME adjustment factor is based on a statistical estimate of the relationship of teaching hospital costs and the IRB. The statistical estimate, generated by regression analysis, has always been lower than the IME adjustment factor used to calculate IME payments. The current IME adjustment factor is 7.7 percent for every 10 percent increase in a hospital's resident-to-bed ratio.

The IME payment, a percentage add-on to the DRG payment, varies among hospitals depending on their IRBs. Using the current IME adjustment factor, a hospital with a 0.25 resident-to-bed ratio receives a 17.9 percent increase in its DRG payment, and a hospital with an IRB of 0.50 receives a 33.7 percent add-on payment.

Since the inception of the PPS, the level of the IME adjustment has declined from the original adjustment of 11.59 percent in the first year of the PPS (FY 1984), to 7.7 percent in the sixth year (FY 1989). The current 7.7 percent adjustment has remained unchanged since October 1, 1988. In 1986, when Congress added the disproportionate share (DSH) adjustment to the PPS, it reduced the IME adjustment to finance part of the new adjustment. Policy makers recognized that many hospitals would receive both types of payments. At the same time, the IME adjustment was modified from a linear adjustment formula to a curvilinear formula. Thus, as the resident-to-bed ratio increases, IME payments increase at a slower rate.

In its attempt to limit Medicare spending, the Administration has repeatedly proposed to reduce the IME adjustment. To date, these proposals have been rejected by Congress on the basis that the IME adjustment also supports the broader social mission of teaching hospitals and their overall financial performance, as measured by total margins, to assure access and quality of care.

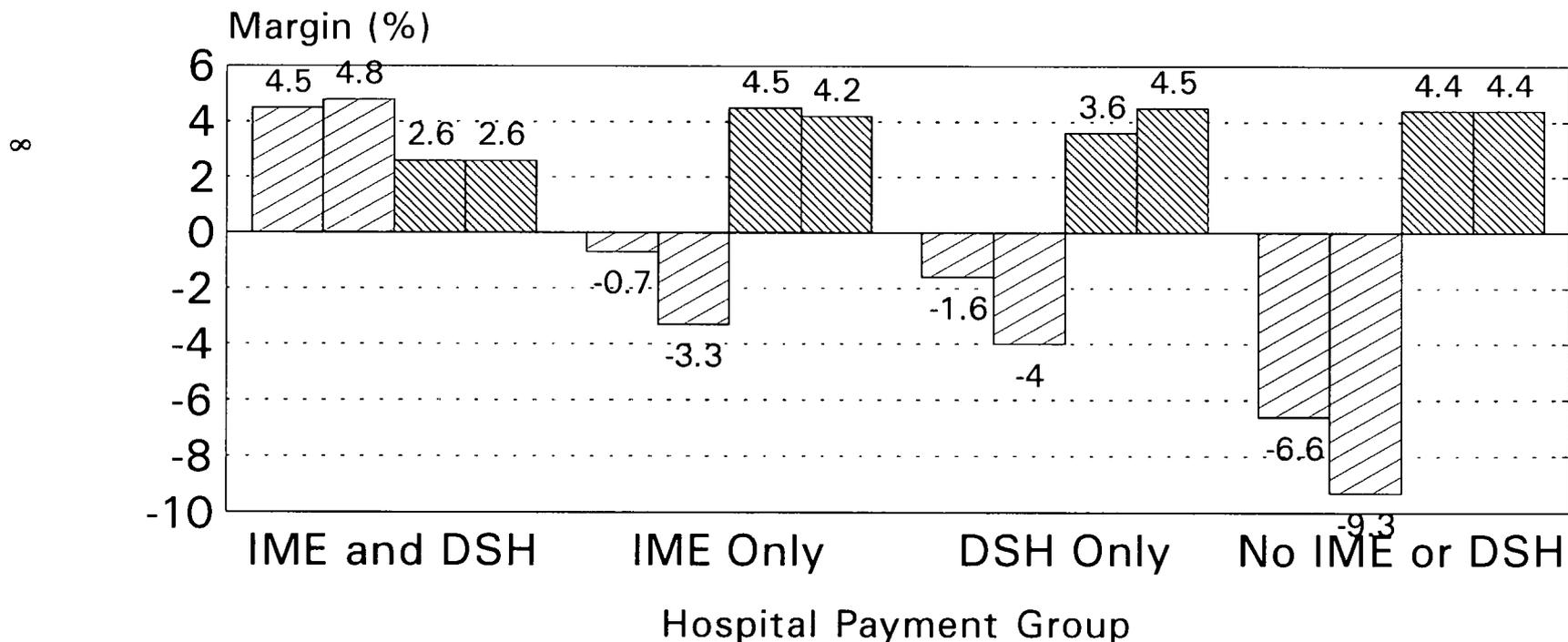
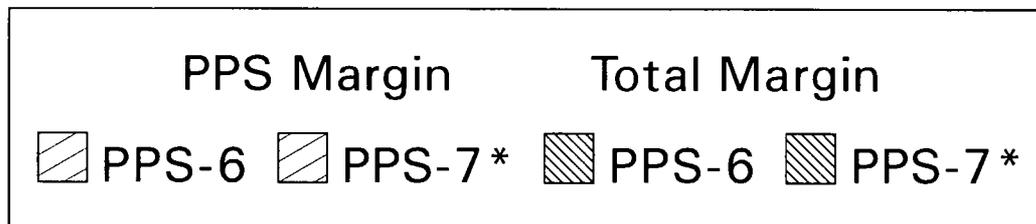
Every year since 1988, ProPAC has recommended a reduction in the IME adjustment in its report to Congress. The commission considers several factors in making its recommendation, including the statistical estimate of the relationship of teaching and hospital costs and PPS and total margins.

Since the beginning of the PPS, teaching hospitals as a group have had higher PPS operating margins than nonteaching hospitals. Yet, on average, teaching hospitals have had lower total margins than any other group of hospitals. Teaching hospitals have asserted these historically lower total margins are partially a result of the large amounts of uncompensated care they provide. However, a ProPAC study to determine whether IME and DSH payments were being effectively targeted toward hospitals with large shares of uncompensated care found no evidence of a relationship between uncompensated care costs and IME payments. ProPAC also found little evidence of a correlation between uncompensated care and DSH payments, except among those hospitals that provided the highest level of unsponsored care. On the other hand, ProPAC found in another analysis that both the IME and DSH adjustments were fairly effectively targeted toward hospitals with low total margins. Hospitals with the lowest total margins received a large share of IME and DSH payments relative to all other PPS payments.

Using data from the sixth and seventh years of the PPS, ProPAC recently studied the PPS and total margins of hospitals by payment status (Figure 2). Hospitals that receive both IME and DSH payments had the highest PPS margins, but the lowest total margins of any group. Their total margins remained stable at 2.6 percent over the two years. Hospitals that receive IME payments only had negative aggregate PPS margins and their aggregate total margin declined from 4.5 percent to 4.2 percent during the period. The "IME payment only" hospital group was the single payment group for which total margins declined. Hospitals that receive only DSH payments also had negative PPS margins and their average total margin

Figure 2

PPS Operating and Total Margins by Payment Status Sixth and Seventh Years of PPS



*PPS-7 data are preliminary.

Source: ProPAC.

increased almost one full percentage point between PPS-6 and PPS-7. Hospitals that receive neither adjustment had the lowest PPS margins, but had stable total margins of 4.4 percent.

Until this year, ProPAC has consistently recommended the savings from a reduction in the IME adjustment should be returned to all hospitals in a budget neutral manner through increases in the basic DRG rates. This year, to target dollars more effectively, ProPAC departed from its earlier positions. For FY 1993, ProPAC recommends the IME adjustment should be reduced from its current 7.7 percent to 7.0 percent and the savings from the reduction should be redistributed only to hospitals that receive both IME and DSH payments, the hospital group with the lowest total margins.

Discussion. The AAMC has vigorously opposed any reduction of the IME adjustment since it was lowered to its current level of 7.7 percent in October 1988. AAMC data analysis in 1989 and 1990 showed that COTH members' relatively high PPS margins were attributable to DSH, not IME, payments. Hospitals that received only IME payments had negative PPS operating margins, while hospitals that received both IME and DSH payments had relatively high PPS margins. It should be noted that the purpose of the DSH adjustment is to increase revenues to reduce financial distress for hospitals with large shares of low-income Medicare and Medicaid patients and patients who are unable to pay for their care. Total margins of both groups declined over the period and were lower than nonteaching hospitals' total margins. In January 1992 the AAMC sent a letter to ProPAC showing the current IME and DSH payment levels have created "rough justice" among hospitals' total margins (Figure 2). Hospitals that receive both IME and DSH payments continue to have lower total margins than any other group. But hospitals that receive only IME payments not only have negative and declining PPS margins, their total margins have also fallen. For these "IME only hospitals" any reduction in the IME adjustment would be particularly harmful. In contrast, total margins of hospitals that receive only DSH payments increased almost one percentage point.

ProPAC's recommendation to reduce the IME adjustment and redistribute the savings through the DSH adjustment would shift payments from one group of teaching hospitals (IME only) to another (IME and DSH). While this recommendation maintains the total size of the IME and DSH pools (\$5.1 billion in FY 1991) and returns the savings to teaching hospitals, its redistribution effect would create winners and losers among teaching hospitals depending on the relative importance of each payment adjustment to an individual hospital. ProPAC's recommendation would redistribute about \$233 million among 610 IME/DSH hospitals. Not all IME/DSH hospitals would get back what they lost from a reduction in the IME adjustment, although some hospitals would receive higher payments under the ProPAC proposal.

National and AAMC data clearly show teaching hospitals, particularly "IME payment only" hospitals, would be harmed by any reduction in the level of the IME adjustment. ProPAC's recommendation would reduce IME payments to all teaching hospitals, but would return dollars only to a subset of teaching institutions.

Issue: Weighting the Count of Interns and Residents in the Indirect Medical Education (IME) Adjustment to Influence Physician Manpower Supply and to Encourage Graduate Medical Education Training in the Ambulatory Setting

Background. A hospital's IME payment is based on a formula that includes a measure of teaching intensity: the ratio of interns and residents-to-beds. To be included in the count for IME payment purposes, residents must be enrolled in approved teaching programs and must be located on site in the inpatient portion of the hospital subject to the PPS or in the outpatient department of the hospital. Residents who are assigned to hospital patient care units exempt from the PPS, such as rehabilitation or psychiatric units, or residents who are assigned to non-hospital settings, such as freestanding family practice centers for example, may **not** be included in the count for IME payment purposes.

Recently some policy makers have expressed interest in using the IME adjustment to create incentives for increasing the supply of generalist physicians and for training in ambulatory settings. One proposed method would weight interns and residents in primary care training programs more heavily in determining the hospital's resident-to-bed ratio, presumably with a corresponding decrease in the weighting of non-primary care specialties, or even elimination of certain types of trainees from the hospital's resident count.

Discussion. This proposal illustrates some policy makers' misunderstanding of the fundamental purpose of the IME adjustment. It is an adjustment to the inpatient DRG prices that recognizes the inability of the DRG classification system to account fully for factors that increase inpatient operating costs in teaching hospitals. These factors include severity of illness, provision of new and unique diagnostic and treatment services, and provision of clinical education programs in the health professions.

Proposals of this nature are fundamentally flawed. They fail to recognize the IME adjustment is part of a prospective payment system for inpatient hospital services. Its purpose is solely related to hospital inpatient care costs, not the costs or the location of graduate medical education training.

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Issue: Adding Capital-Related Costs to the Calculation of the Statistical Estimate for the Indirect Medical Education (IME) Adjustment

Background. Since the implementation of the PPS for operating costs in 1983, Medicare payments for hospitals' capital-related costs were made on an institution-specific, cost basis. On October 1, 1991, a prospective payment system for inpatient capital costs was implemented with many of the same features as the PPS for operating costs. Hospitals are now paid for inpatient capital costs on an average capital cost per case basis (the Federal rate), with payment adjustments that recognize variations in capital costs beyond the

hospital's control. Hospitals may be paid under fully prospective or "hold harmless" methodologies. Similar to the PPS for operating costs, the capital PPS will be phased in over a ten year period during which an increasing portion of payments will be based on the Federal prospective average cost rate.

An individual hospital's Federal rate is adjusted by the many of the same factors used to adjust payments in the operating cost PPS. Its capital payments are adjusted by its case mix, its area wage index, location in a large urban area and outliers. Hospitals may also receive an IME and/or a DSH payment adjustment. However, under the capital PPS the IME and DSH adjustments are not comparable to the same payment adjustments for operating costs. For example, the IME adjustment for capital is 2.8 percent, not 7.7 percent as in the operating PPS, and the capital PPS uses the ratio of residents per patient, not per bed, in the IME adjustment formula. In addition, the formula for the IME adjustment for PPS capital payments differs slightly from the IME adjustment for operating payments.

Commenting on HCFA's proposed capital PPS in May 1991, ProPAC recommended that the capital PPS should use the same payment adjustments as found in the operating PPS. ProPAC argued that "one of the major advantages to a prospective, per case payment system for capital is that it eliminates the arbitrary distinction between capital and operating payments to hospitals." To accomplish this objective, the commission recommended that HCFA apply the same adjustments to capital and operating payments, and within two years, recalculate the adjustments based on combined capital and operating costs. ProPAC noted that the "current policy-determined" IME adjustment for operating payments should also apply to capital payments. HCFA's proposed rule contained no indirect medical education adjustment for capital costs, but the capital PPS as implemented includes an IME adjustment of 2.8 percent.

In December 1991 ProPAC staff analyzed the relationship of teaching intensity and Medicare capital-related costs and found no statistical basis for an IME adjustment in the capital PPS. In other words, Medicare capital costs per discharge did not change with increases in teaching intensity. For operating costs, however, this relationship was 5.7 percent for every 10 percent increase in the hospital's resident-to-bed ratio. When ProPAC analysts examined the relationship of combined Medicare operating and capital costs to teaching intensity, they found a 5.2 percent increase in combined costs was associated with a 10 percent increase in the IRB. ProPAC also examined both capital and operating IME payment formulas and found no statistical basis for preferring either formula over the other.

In its March 1992 **Report to the Congress**, ProPAC recommends that by FY 1994 the statistical estimate for the IME adjustment should be consistent for prospective operating and capital payments and that in the long term the level of the IME adjustment should be based on combined operating and capital costs. In its final rule HCFA agreed with ProPAC on using combined capital and operating costs to determine the level of the payment adjustments, but rejected as inappropriate the use of the current operating adjustment in the

capital PPS on the basis that the current levels of the IME and DSH operating adjustments exceed the levels supported by empirical analysis.

Discussion. The complexity of the capital PPS with its two payment methods, special payments available only during the ten year transition period, and mandated budget neutrality adjustments makes it difficult to assess the impact of the capital PPS on teaching hospitals as a group. In addition, hospitals in large urban areas, teaching hospitals and large bed size hospitals tend to have higher than average capital costs. The capital cost variation **within** these groups of hospitals is almost as great as the variation **among** these groups.

The definition and application of the payment adjustment factors to the Federal capital payment rate make it impossible to determine exactly how the statistical estimate would change by combining capital and operating costs in the calculation of the IME adjustment. ProPAC's 5.2 percent statistical estimate generated by combined costs represents today's best guess of the empirical basis for the IME adjustment until all payment adjustments and rules are consistent in both systems. However, since ProPAC found no statistical basis for an IME adjustment in the capital PPS, the statistical estimate for combined costs will always be less than the estimate for operating costs alone. Research has consistently shown a relationship between the IRB and operating cost per case.

Using the combined cost statistical estimate of 5.2 percent to calculate payments, the Federal rate would pay teaching hospitals' capital costs more generously than under the current capital PPS. But IME payments under the operating PPS would decrease significantly. In the current operating IME adjustment of 7.7 percent, Congress has recognized the statistical estimate and the importance of the broader social mission of teaching hospitals and their overall financial viability in maintaining access and quality of patient care.

Staff believe in principle the same incentives encouraged by the operating PPS should be incorporated in the capital PPS. To accomplish this objective, the distinction between capital and operating payments should be eliminated and a consistent set of payment adjustments should be applied to combined capital and operating payments.

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Issue: Using Residents Per Patient, as Opposed to Residents Per Bed, in the Calculation of the Indirect Medical Education (IME) Adjustment

Background. The current measure of teaching intensity used for IME operating payments is defined by law as the ratio of residents-to-beds. Last year, HCFA submitted a legislative proposal to use residents per average daily census, or residents per patient, as the measure of teaching intensity. In the capital PPS regulation HCFA also adopted the residents per patient measure because of "concerns about the potential for manipulation of the number of beds in order to maximize the amount of the adjustment." HCFA cited a report by the General

Accounting Office (GAO) in which bed counting policies were not uniformly applied across hospitals.

ProPAC analyzed both measures and found no statistical basis for preferring the per patient measure of teaching intensity. However, the per patient measure has important redistributive implications. IME payments would be shifted from high occupancy teaching hospitals in urban areas with large teaching programs, large shares of low-income patients and low total margins to suburban or rural teaching hospitals with smaller teaching programs, smaller shares of low-income patients and relatively high total margins.

Discussion. While patients may be easier to count than beds, the measure of residents per patient would redistribute dollars in a way that is inconsistent with other payment policy objectives, such as assuring the overall financial viability of teaching hospitals with low total margins. On the other hand, some argue that lower occupancy teaching hospitals must still maintain the full complement of services for clinical education purposes. In such cases, the resident per patient measure may appropriately redistribute funds to hospitals that are committed to offering residency training programs. However, it is also true that a policy which rewards low occupancy would be very difficult to support.

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Issue: Changing Medicare Payments for Direct Graduate Medical Education Costs to Influence the Specialty Distribution of Physician Manpower

Background. The Medicare program has always shared in the direct costs of graduate medical education which include resident stipends and benefits, salaries and benefits for faculty supervision of trainees, classroom space, supplies, clerical support, and allocated overhead. In 1986, however, Congress passed legislation (COBRA 1985) that changed the method of payment for direct graduate medical education costs from an allowable cost reimbursement "pass-through" to a per resident amount based on 1984 or 1985 costs and annually adjusted for inflation. The adjusted per resident amount is then multiplied by the number of full-time equivalent (FTE) interns and residents in the hospital complex during the payment period. Although COBRA limits payment of allowable direct graduate medical education costs, it still acknowledges the historical scope and variation of direct graduate medical education costs.

Congress also limited the number of years that the Medicare program would support its share of a resident's training. COBRA restricted Medicare's share of graduate medical education payments to the costs associated with those residents within the minimum number of years of formal training necessary to satisfy specialty requirements for initial board eligibility, plus one year, up to a maximum of five years. Residents are counted as 1.0 FTE for the residency period required for initial board certification, plus one year, not to exceed a total of five years. Beyond the lesser of these two limits, residents who remain in approved

programs are weighted at 0.5 FTEs. The limit was suspended, however, for up to two years for training in an approved geriatric fellowship program.

In enacting these changes, Congress narrowed the Medicare program's open-ended commitment to the support of graduate medical education. In 1990, both the Administration and the House of Representatives Ways and Means Health Subcommittee proposed changes in direct graduate medical education payments to provide incentives for primary care training by reducing the present support for non-primary care specialties. In addition, the Administration maintained its proposal would reduce the variation in direct graduate medical education payments among hospitals. Both plans called for differential per resident payments to hospitals based on specialty:

- The Administration's proposal would have established a per resident payment based on the national average salary of residents in FY 1987 updated by the Consumer Price Index. Primary care residents would be weighted at 240 percent of the per resident payment amount, non-primary care trainees in their residency period required for initial board certification would be weighted at 140 percent, and non-primary care residents beyond the initial residency period would be weighted at 100 percent.
- The House Ways and Means proposal would have retained the same base year per resident calculations set forth in COBRA, but FTE trainees in years 1 through 3 would be weighted based on specialty choice: internal medicine and pediatric residents would be counted as 1.0 FTE; residents in family medicine, "general" internal medicine and "general" pediatrics (undefined) would be counted as 1.10 FTE; and all other residents in years 1 through 3 would be counted as 0.90 FTEs. Each FTE beyond the third year of residency would be counted as 0.80 FTE.

While neither proposal was adopted by Congress last year, similar proposals are likely to be made by Congress and the Administration for FY 1993.

In 1989, the AAMC Executive Council reaffirmed a set of existing policies on graduate medical education financing that were originally developed by the Committee on Financing Graduate Medical Education and adopted by the Executive Council in 1986 during the debate over the COBRA legislation:

- residents in approved training programs should be funded largely by payments to teaching hospitals by patient care payers at least through the number of years required to achieve initial board eligibility in their chosen discipline.
- one additional year of funding beyond initial board eligibility should be provided from teaching hospital revenues for fellows

in accredited training programs to the extent that the hospital funded such training in 1984.

- an individual should be supported from patient care payers' payments to teaching hospitals for a maximum of six years of graduate medical education.

To address the need for an explicit policy on the acceptability of financial disincentives in graduate medical education funding, the Executive Council adopted an additional policy in 1989:

- while public and private organizations may adopt positive financial incentives to encourage physicians to train in particular disciplines, they should not adopt financial disincentives for a particular discipline during the period of its initial board eligibility.

Discussion. In testimony before Congress and other bodies such as the Physician Payment Review Commission, the AAMC has opposed the Administration and the House Ways and Means proposals on the basis that manipulation of payments to hospitals does not influence medical students' specialty choice. Both proposals assume that there is a shortage of primary care residency positions, when there is actually an abundance of residency training slots in the primary care disciplines.

The Administration's proposal is a particularly dramatic departure from the current payment methodology. In its promise to reduce the amount of variation in graduate medical education, it fails to recognize the full scope of graduate medical education costs that have resulted from legitimate historical patterns in hospital financial support and accounting practices. Based solely on residents' salaries, it would certainly mean reduced payments for the costs of supervisory faculty salaries and benefits for non-primary care residency programs, potentially affecting the quality of both patient care and graduate medical education training programs.

The House Committee proposal would have used the current COBRA methodology, i.e., the base year per resident amount adjusted for inflation, which recognizes the full scope and variation of graduate medical education costs, but would introduce stronger incentives for primary care training than in the current payment methodology. The AAMC's current position to oppose financial disincentives for a particular discipline during the period of its initial board eligibility made the House Committee's proposal unacceptable, as it would weight residents in the initial training years in all specialties other than internal medicine and pediatrics at less than 1.0 FTE. In addition, the plan would not recognize the costs of trainees in longer training programs as all residents beyond the third year of residency, regardless of specialty, would be weighted at less than 1.0 FTE.

Similar proposals to change Medicare payments to hospitals to influence physician manpower supply will probably be made in the coming year. These proposals are likely to be approaches to reduce total payments for the direct costs of graduate medical education and/or reduce support in non-primary care disciplines.