ANALYSIS IN BRIEF

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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Impact of 2000 Medicare Legislation on Teaching Hospitals' Medicare Direct Graduate Medical Education Payments

Nearly half of the nation's teaching hospitals will receive Medicare payment increases associated with direct graduate medical education (DGME) under legislation enacted in December 2000. And because they generally educate larger numbers of residents, members of the AAMC's Council of Teaching Hospitals and Health Systems (COTH) affected by the legislation will receive an average increase three times that of other teaching hospitals.

The legislation — the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) — modified a change in the calculation of Medicare DGME payments that was first introduced in the Balanced Budget Refinement Act of 1999 (BBRA).

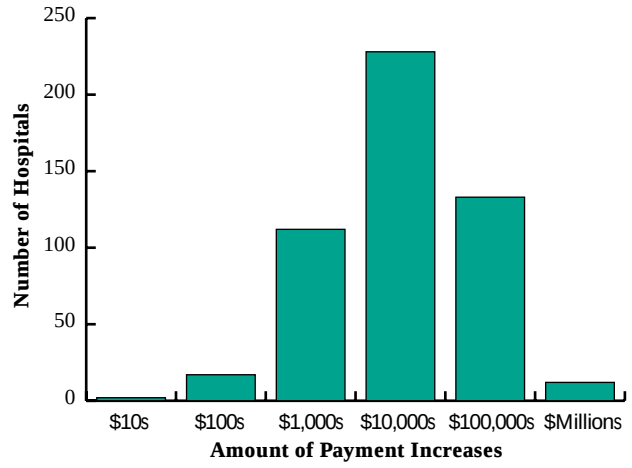
DGME payments reimburse teaching hospitals for Medicare's share of the costs of educating residents, including residents' salaries and fringe benefits, salaries associated with faculty supervision, and other direct costs. Medicare pays a portion of these amounts based on the care provided to Medicare beneficiaries by each hospital (generally 30 to 35 percent of all care); the remaining costs must be funded from other revenue sources.

Historically, Medicare DGME payments have been based on hospital-specific costs per resident, or "per-resident amounts" (PRAs), in a base year (generally 1984) adjusted for inflation. Because of differences in how direct GME costs were financed and accounted for in 1984, there is substantial variation in PRAs across hospitals.

Under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, which increases the floor for Medicare direct graduate medical education (DGME) payments:

- **Nearly half of teaching hospitals will receive increased annual DGME payments, averaging $140,000 per hospital.**
- **About one-third of the AAMC Council of Teaching Hospitals and Health Systems' 300 non-federal hospital members will receive increased annual DGME payments, averaging $460,000 per hospital.**

Figure 1: Distribution of Medicare DGME Payment Increases Due to BIPA



For various reasons, including the fact that the base year is 1984, many teaching hospitals' PRAs understate their current actual DGME costs. To address this issue and to reduce the variation in PRAs across hospitals, the BBRA established a new methodology for DGME payments by setting payment "corridors." Beginning in federal fiscal year (FFY) 2001, the BBRA called for each hospital's PRA to be compared with a national average PRA adjusted for specific geographic areas to account for differences in labor costs. This average is referred to as the "locality-adjusted national average."

The BBRA provided for a floor and ceiling of 70 percent and 140 percent of the locality-adjusted national average, respectively. Hospitals below the floor have their PRAs increased to 70 percent, while hospitals above the ceiling have their PRAs frozen for 2001 and 2002 and will receive reduced inflationary increases for 2003-2005. Nearly 300 teaching hospitals were below the floor and received increased DGME payments, while about 130 hospitals were at the ceiling and therefore did not receive inflationary increases.

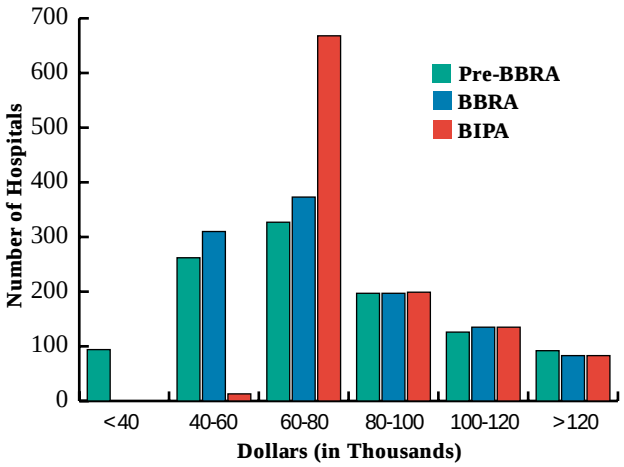
While making no changes to the payment ceiling, BIPA expanded the pool of hospitals eligible for additional DGME payments by increasing the floor from 70 percent to 85 percent of the locality-adjusted national average PRA, beginning in FFY 2002. The Congressional Budget Office estimates that the provision will bring an additional $300 million in DGME payments to teaching hospitals over the next five years.

According to an AAMC analysis based on 1996 Medicare hospital cost report data, 505 of the nation's approximately 1,100 teaching hospitals will see increased DGME payments due to BIPA. Of these hospitals, 292 benefited from both the BBRA and BIPA provisions because they had PRAs below 70 percent of their locality-adjusted national average; the remaining 213 hospitals benefited only from BIPA because their PRAs were between 70 and 85 percent of the average.

For the 505 hospitals whose PRAs were raised to the 85 percent floor, BIPA increased average per-resident payments about $8,500 and overall payments an average of about $140,000 per year. However, the DGME payment increases differ substantially across hospitals, ranging from less than $100 per year to more than $1 million. (See Figure 1.) These levels vary in large part because of the number of residents educated in a particular hospital. Hospitals with relatively few residents will see only small increases, even if their PRA was substantially below the 85 percent floor. Conversely, hospitals below the floor that educate large numbers of residents and treat significant numbers of Medicare patients will see substantial DGME payment increases as a result of BIPA.

About a third of the AAMC's non-federal acute care COTH members will benefit from the BIPA provision. Forty-two COTH members had PRAs below the 70 percent floor, while 58 had PRAs between 70 and 85 percent of their locality-adjusted national average. While they account for only a fifth of all the teaching hospitals affected by the Medicare DGME provisions of BIPA, COTH members educate a disproportionate number of residents. Consequently, COTH members will receive about 65 percent of the increases in DGME payments due to BIPA, with an average annual increase of $460,000 per hospital.

Figure 2:BBRA and BIPA Narrow the Distribution of Per-Resident Amounts (2002)



The BIPA DGME provision will also reduce variation in PRAs across hospitals. Prior to the BBRA and BIPA, 59 percent of teaching hospitals had PRAs between $60,000 and $120,000 per year. After BBRA, 64 percent of hospitals were within this range — a figure that increased to 91 percent after BIPA. (See Figure 2.)

This analysis focuses on the impact of BIPA on Medicare DGME payments. However, BIPA provisions affect many other Medicare and Medicaid payment policies, including the Medicare inpatient payment update, Medicare indirect medical education payments, and Medicare disproportionate share hospital payments. Analyses to examine the overall impact of BIPA on teaching hospitals are currently under way.

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To learn more about the provisions in BIPA, visit the AAMC's Governmental Affairs Web site at http://www.aamc.org/advocacy/washhigh/00dec22/_1.htm.

Members of the AAMC Council of Teaching Hospitals and Health Systems, Council of Deans, and Council of Academic Societies can access individual estimates for their institutions at the AAMC's private COTH Web site at http://www.aamc.org/private/coth/dgme/start.htm.