

ISSUE BRIEF

Federal and State Perspectives on GME Reform

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Federal and State Perspectives on GME Reform

Although an occasional federal or state legislator will pose the question of why the public should fund the training of physicians, explicit financial support of graduate medical education (GME)¹ seems to be a standard budget item in the federal Medicare program and in most state Medicaid programs. The amount and allocation of the support are more doubtful, however. Various proposals have come forth in the last decade, some aimed at directing the funds to certain workforce goals, some at diverting or dividing teaching hospitals' direct pipeline to GME dollars (particularly for Medicare), and some at broadening the base of public subsidization to the private sector.

One program, the Children's Hospital Graduate Medical Education (CHGME) program, established by the Healthcare Research and Quality Act of 1999, relies on discretionary funding, as do certain health professions education programs, such as advanced practice nursing and family medicine, that are in Titles VII and VIII of the Public Health Service Act. The CHGME program funnels GME payments to approximately 60 freestanding children's hospitals through the federal authorization and appropriation process. Because the Medicare and Medicaid entitlements in the Social Security Act are ongoing, whereas authorizations and appropriations are subject to renewal by Congress and the president, the CHGME approach is unsettling to Medicare GME recipients.

Medicare GME this year is expected to provide \$3 billion in direct payments to teaching hospitals for the salaries and fringe benefits of residents and supervisory faculty, as well as overhead costs (generally called "direct graduate medical education," or DGME).² The program is expected to pay \$5.2 billion in indirect payments to teaching hospitals to recognize, according to the Social Security Amendments of 1983, the higher Medicare inpatient costs they incur as a result of being teaching institutions. The payments, under the label of "the indirect medical education (IME) factor," are adjustments to diagnosis-related group (DRG) rates under the Medicare prospective payment system (PPS). It is not known how many billions *in toto* the 45 Medicaid GME-paying states, plus the District of Columbia, will pay this year; the amount for 1998 was estimated to be between \$2.3 billion and \$2.4 billion.³ According to the Association of American Medical Colleges

(AAMC), non-Medicaid state appropriations were approximately \$3.3 billion in 1998-1999.

In addition, some private insurers recognize GME costs through higher payments to teaching hospitals than to nonteaching hospitals for services provided their members, although more stringent financial arrangements between insurers and hospitals have threatened such payments in recent years. It is important to keep in mind that the greatest proportion of GME financing comes from patient care revenues, not only from payers that implicitly provide higher payments for that purpose but also from faculty practice plan dollars that subsidize clinicians, clinical departments, or medical schools. According to an estimate presented in April 2001 by Marilyn Biviano of the Bureau of Health Professions (BHP), Health Resources and Services Administration (HRSA), Medicare provides 40 percent, Medicaid 10 percent, and BHP 1 percent of GME financing, and "all other" contributes 49 percent.⁴

Because GME payments are entrenched in law and practice, changing their goals, recipients, and formulas—the foci of reform proposals—is one of the most challenging aspects of health policy. Given the fact that GME payments are commingled with other funds, not only patient service but also clinical research dollars at teaching hospitals, it is even daunting to track where the funds go. For these reasons, most reformers have not gotten very far. Some have questioned the proportion of

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specialists over generalists emerging from residency programs and considered ways of changing the balance. Some have made minor attempts to shift the locus of training (and the dollar flows) from inpatient to ambulatory settings. And, some have looked at broadening the base of support through establishment of an all-payer fund to supplement public with explicit private dollars. The proposal has lingered since 1994, when academic medicine and the managed care industry, and others (but not the American Medical Association) signed onto an all-payer fund provision in the Clinton administration's Health Security Act proposal.

For Medicare, the main GME reform proposals seem to fall into the following categories: (a) tinkering with the existing system, (b) scuttling the present system for an approach that would combine DGME and IME into a targeted program, (c) shifting DGME and IME funds from entitlement to appropriated dollars, and (d) establishing an all-payer system. Because each state has its own Medicaid program, with only Alaska, Idaho, Illinois, Montana, and South Dakota (along with Puerto Rico) not reporting any funds to GME, the Medicaid issues are more difficult to categorize. However, because each state Medicaid program is a separate entity—albeit in partnership with the federal government, which sets mandatory and optional criteria and provides matching funds—the states reflect diversity in the Medicaid GME approaches they use. In some cases, they also are willing to experiment with new GME initiatives to try to achieve educational and workforce goals. The more adventurous states include Michigan, Minnesota, New York, Tennessee, Texas, and Utah.

This Forum session will explore federal and state perspectives on GME reform. After underlining the basis for explicit public financial support of GME, the meeting will look at the impact on a state basis. Contributing to the discussion will be an analysis of Medicare GME payments across various states, as well as a look at state Medicaid and discretionary approaches and their relevance to health workforce planning. The session will also explore the role of individual hospital variations—the characteristics or practices of individual hospitals that result in different GME payment amounts. These are expected to lead to discussion among presenters and participants of various proposals for GME reform.

SOME JUSTIFICATIONS FOR PUBLIC SUPPORT OF GME

The rationale for devoting Medicare and Medicaid funds to GME goes back to the mid-1960s, when the

two programs were enacted. At the time that drafters were devising the two programs, the federal government was concerned about the number and distribution of physicians in the United States and was promoting policies to build the physician workforce.

Ratios of total physicians per 100,000 total population varied little between 1950 and 1965. However, ratios in subsequent years reflect substantial changes in physician supply. In 1997, there were over 98.6% more physicians per 100,000 total population than 37 years earlier—142 (1960) and 282 (1997). In absolute counts, the total physician population grew by 190.5% between 1960 and 1997, from 260,484 to 756,710, while the total population increased by only 45.9%, from approximately 183 million to over 267 million in the same interim. These data indicate physician growth at a rate over four times faster than that of the total population.⁵

Moreover, the drafters of the Medicare enacting legislation relied on private insurance models that recognized GME costs as a societal responsibility. The concept of GME being a public good remains, although few policy people question the adequacy of the supply of physicians. Some, however, voice doubts about the geographic and specialty distribution, as well as the proportion of international medical graduates (IMGs) to U.S. graduates.

To underline the legitimacy of GME, academic medicine cites this language in the House of Representatives and Senate reports that accompanied the Medicare legislation:

Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.⁶

That is, the Hospital Insurance (HI)—or Medicare Part A—Trust Fund, financed by a payroll tax, should underwrite a portion of such activities.

The Case for Teaching Hospitals

In a recent article published in *Academic Medicine*, Ralph W. Muller, immediate past chair of the AAMC, gave the AAMC's rationale for public support of teaching hospitals and medical schools:

- About half, overall, of teaching hospitals' patients have public insurance. In 1998, approximately 30 percent of patients treated by teaching hospitals were Medicare beneficiaries and 20 percent were Medicaid recipients.

- Teaching hospitals “provide services that are not generally available in all hospitals.” They are the “specialty centers” to which people go for advanced specialized care. For example, in contrast to 6 percent of all hospitals, 66 percent of teaching hospitals performed organ transplants in 1998. Compared with 24 percent of all hospitals, 73 percent of teaching hospitals gave trauma care. As opposed to 12 percent of all hospitals, 65 percent had neonatal units.
- According to “mounting evidence,” teaching hospitals “do better in providing higher quality care. An analysis of care in ‘high-volume hospitals’ found that patients referred have significantly better mortality results than do those in low-volume hospitals for several major procedures and diagnoses.”
- Teaching hospitals “not only provide specialty care but also serve their communities’ need for primary care.” The settings in which the care is provided “are diverse, from hospital-based clinics to federally qualified health centers (FQHCs) located in neighborhoods that are underserved.”
- Teaching hospitals provide “complex care.” Patients tend to “be seen by several doctors, who receive consults from others, and attract the considerable interest of a team of medical students, residents, and fellows.” Medical centers are

organic entities that have grown over decades to handle complicated tasks and complex missions.. The people who are skilled in handling the challenges of [medical] centers are not optimized as economically efficient actors but instead are organized—institutionally, culturally, and even politically—to meet complicated situations within a team of highly talented individuals.
- Teaching hospitals are social institutions. They may be the largest employers in their communities, have emergency rooms open 24 hours a day, and operate social-service units that link patients to other institutions in their communities.⁷

Challenges from Others

Others think public support of GME can be useful in achieving certain health professions education and health service goals. These include organizations (such as the National Association of Community Health Centers) that want to direct GME funds from teaching hospitals to ambulatory facilities as well as organizations (such as the American Academy of Family Physicians) that view GME funds as crucial in shaping the health workforce.

Among their goals are governing the rate of growth in the supply of physicians, providing incentives for a higher proportion of generalists to specialists, increasing the numbers of ethnic and racial minorities in the physician workforce, and assuring safety-net providers. The Council on Graduate Medical Education (COGME) included these goals in a document—the “Fifteenth Report”—that it issued on GME financing at the end of 2000.⁸

MEDICARE GME POLICY

Medicare GME payments “are linked to services provided to Medicare beneficiaries,” COGME’s Fifteenth Report states.⁹ That is, rather than recognizing medical education costs per se, they address the link between medical education and health care services provided to patients covered by the Medicare program. As the major public payer of GME costs, Medicare law defines the program’s responsibility in terms of the following: (a) Medicare DGME expenditures for the salaries and benefits of medical residents, the faculty who supervise them, and the personnel who handle the clerical work concerning them, as well as for the allocated overhead costs of the institutions that train them, and (b) the Medicare IME factor for patient care costs—not captured by DGME—that are due to teaching. (While Medicare GME obviously emphasizes the training of physicians, it is important to note that some of the funds go to the education of nurses. For example, teaching hospitals with diploma nursing schools, which have declined over the past two decades as organized nursing has pushed for baccalaureate and even more advanced nurses, receive some Medicare GME funds for nurse training.)

Changes in DGME over Time

For the first 20 years of the Medicare program, Medicare picked up “allowable” teaching hospital costs. However, a series of omnibus reconciliation measures limited reimbursement of the costs:

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, actually enacted in 1986) limited the costs to a capitated per-resident amount (figured on a hospital-by-hospital basis) and to a defined number of residency years for full Medicare reimbursement.
- The Balanced Budget Act of 1997 (BBA) capped the number of residents who could be counted. The BBA also added a provision permitting the Medicare program to pay certain ambulatory sites for DGME costs. These sites include Medicare-participating FQHCs, rural health clinics, Medicare+Choice

organizations, and other entities as designated by the Medicare program. The conference report that accompanied the measure expressed concern over Prospective Payment Assessment Commission and Physician Payment Review Commission studies¹⁰ showing wide variation in per-resident amounts from hospital to hospital.

- The Balanced Budget Refinement Act of 1999 (BBRA) created both a minimum payment level and a maximum payment level for hospital per-resident amounts.
- The Benefits Improvement and Protection Act of 2000 (BIPA) raised the minimum level but did not change the maximum level.

Variations in GME payments in selected states are featured in a paper—commissioned by the California HealthCare Foundation—by Thomas R. Oliver, Ph.D., and Atul Grover, M.D., of Johns Hopkins University, as well as Philip R. Lee, M.D., of the University of California at San Francisco.¹¹ The paper examines variations in Medicare GME payments that occur in states that receive the highest amount of DGME and IME support. It reports the variations, tracks their growth since the implementation of PPS, and seeks to give reasons for them. For example, the paper includes a table that presents Medicare GME payments for the top five teaching hospitals in six states (see Table 1).

Because both the BBRA and BIPA contained provisions—by establishing floors and ceilings—to narrow the variation in DGME payments, the profiles of hospitals and states may look somewhat different in the future, according to Michael Hash of Health Policy Alternatives.¹² It is difficult to estimate exactly how the distribution of payments will change. Although DGME is smaller than IME in terms of GME payments, it arguably reflects differences in payment that are the result of organizational decisions and circumstances that determine how to finance the costs of residency programs. Since residency stipends do not vary widely across the country, faculty costs and overhead expenses have generally been found to account for most of the variation. Moreover, the significance of faculty practice plans, volunteer faculty, fully salaried faculty, and specific overhead costs needs to be determined.

Because Medicare PPS was designed to be a competitive “winners and losers” program, examining state variations is bound to be controversial. The Oliver, Grover, and Lee paper raises significant questions about what is driving Medicare GME costs. It does so even though aggregating GME expenditures within states may

obscure some of the characteristics or practices of individual hospitals that result in very different GME payment amounts. For example, for DGME, the hospital’s number of residents, Medicare inpatient days, and accounting practices at the start of PPS (when the level of cost per resident was established as a basis for DGME costs) are the primary determinants of payment. For IME, a specific hospital’s number of residents, staffed beds, area wage index, urban or rural location, and Medicare inpatient utilization rate are the major determinants.

Declines in the IME Factor

When Congress passed the Social Security Amendments of 1983 mandating a DRG-based PPS for Medicare inpatient services, it included report language calling the IME “a proxy to account for a number of factors that may legitimately increase costs in teaching hospitals.” (For instance, an often-cited factor is a teaching hospital’s having a more severely ill patient caseload than is accounted for in its case-mix index.) Because the IME is not an *implicit* educational payment, some have advocated giving it a strict definition. For example, COGME, in its Fifteenth Report, proposes that “IME payments should be set at no more than the analytically justified level for teaching activities.”¹³

Beginning with hospitals’ 1984 fiscal year, the first year of PPS, IME was an 11.59 percent add-on to each DRG rate (for a Medicare patient) for every 10 percent increase in a teaching hospital’s intern/resident-to-bed (IRB) ratio. Subsequent omnibus reconciliation measures amended the IME factor provision as follows:

- COBRA reduced the IME factor to 8.1 percent for fiscal years (FYs) 1986 and 1987 and to 8.7 percent in future years.
- The Omnibus Budget Reconciliation Act of 1987 (OBRA) reduced the IME factor to 7.7 percent, beginning in FY 1989.
- The BBA reduced the IME factor to 6.5 percent for FY 1999. It also provided for the factor to decline to 6.0 percent in FY 2000 and to 5.5 percent in FY 2001, provisions amended by the BBRA (see next bullet).
- The BBRA set the IME factor at 6.25 percent for every 10 percent increase above 0.10 in the IRB ratio and delayed for one year decreasing the factor to 5.5 percent—as provided in the BBA.
- BIPA further delayed the BBA reductions in the IME reduction, thereby restoring the IME factor to 6.5 percent until FY 2003, when it is slated to decline to 5.5 percent.

Table 1
Medicare GME Payments per Resident and Discharge
for Top Five Recipients in Selected States, FY 1996

State/Hospitals	Total GME IME+DME (millions)	DME per Resident	Adjusted DME per Resident*	IME per Discharge	Medicare Share of Days	Hospital Residents	Medicare Discharges
CALIFORNIA							
UC Davis	\$29.76	\$8,911	\$37,129	\$5,408	24%	410	4,828
Cedars-Sinai	\$30.80	\$21,316	\$49,572	\$2,091	43%	228	12,404
UC San Francisco	\$34.08	\$10,179	\$46,268	\$7,060	22%	529	4,064
Stanford University	\$43.28	\$20,617	\$64,428	\$5,801	32%	323	6,312
UC Los Angeles	\$43.85	\$11,169	\$38,514	\$5,150	29%	574	7,269
FLORIDA							
Orlando Regional HCS	\$9.53	\$20,221	\$67,403	\$687	30%	123	10,253
Tampa General Hospital	\$10.90	\$9,806	\$33,814	\$1,656	29%	196	5,422
Mount Sinai Medical Ctr	\$14.04	\$29,672	\$60,555	\$1,313	49%	145	7,414
Jackson Memorial	\$18.49	\$6,904	\$57,533	\$2,998	12%	614	4,753
Shands Teaching Hospital	\$26.56	\$19,217	\$73,912	\$4,077	26%	380	4,723
MASSACHUSETTS							
Baystate Medical Center	\$30.26	\$36,814	\$102,261	\$2,472	36%	237	8,710
U. Mass. Medical Center	\$35.14	\$16,826	\$42,065	\$5,937	40%	304	5,057
Brigham & Women's Hosp	\$37.07	\$14,900	\$62,083	\$4,220	24%	456	7,173
Beth Israel Hospital	\$39.68	\$32,879	\$91,331	\$3,674	36%	301	8,105
Mass. General Hospital	\$63.23	\$30,325	\$67,389	\$3,636	45%	503	13,196
NEW YORK							
Long Island Jewish	\$49.63	\$33,203	\$92,231	\$4,298	36%	476	7,869
Beth Israel Hospital	\$63.40	\$66,250	\$165,625	\$2,074	40%	442	16,452
Presbyterian-Columbia	\$63.78	\$21,395	\$62,926	\$4,358	34%	655	11,420
Mount Sinai Hospital	\$67.71	\$41,752	\$119,291	\$3,881	35%	538	11,660
Montefiore Medical Ctr	\$95.00	\$50,342	\$122,785	\$3,882	41%	770	14,485
PENNSYLVANIA							
Allegheny General Hosp	\$30.53	\$26,868	\$62,484	\$2,391	43%	241	10,060
Albert Einstein Med Ctr	\$31.72	\$48,604	\$118,546	\$3,089	41%	250	6,334
Thomas Jefferson	\$48.16	\$29,243	\$79,035	\$3,837	37%	485	8,853
Univ. of Pennsylvania	\$57.68	\$31,407	\$95,173	\$5,326	33%	521	7,758
UPMC Presbyterian	\$59.05	\$34,957	\$74,377	\$3,931	47%	396	11,498
TEXAS							
Baylor University	\$17.84	\$29,110	\$78,676	\$1,100	37%	148	12,302
Univ. of Texas (Houston)	\$19.38	\$10,926	\$57,505	\$2,780	19%	474	5,109
Hermann Hospital	\$20.60	\$7,135	\$33,976	\$4,074	21%	383	4,387
Scott and White Memorial	\$25.79	\$65,318	\$138,974	\$2,056	47%	143	8,000
Methodist Hospital	\$27.20	\$20,839	\$42,529	\$1,959	49%	196	11,797

* The adjusted rate (DME per resident/Medicare share of inpatient days) reflects the amount a hospital would have received if it treated only Medicare patients.

Source: HCFA data as presented in "Variations in Medicare Payments for GME in California and Other States."

Table 2, prepared by the Division of Health Care Affairs of the Association of American Medical Colleges (AAMC), charts the IME percentage add-on to the DRG payment for illustrative intern-and-resident-to-bed ratios incorporating changes mandated by the BBA, BBRA, and BIPA.

STATE MEDICAID POLICIES

Even before the creation of the Medicaid program—going back to just after World War II—most states spent some of their budgets on medical education, mainly for undergraduate training. With the inception of Medicaid in all states except Arizona (which started its program in 1982), states started contributing the second largest amount of explicit GME funding.

A Profile of the States

Tim Henderson, program manager and director of the Center for Primary Care and Workforce Analysis, National Conference of State Legislatures (NCSL), has done many of the analyses of Medicaid GME financing that are available to policymakers. According to a study that Henderson conducted for NCSL in 1998 and 1999 and reported in *Health Affairs*,

- A total of 45 states and the District of Columbia paid for GME at some level.
- Of the 45 states and the District of Columbia, 43 paid for GME in their fee-for-service (FFS) programs. Of these, 24 made both IME and DGME payments and 11 did not distinguish between the two. Thirty-five of the states that paid for GME under FFS did so through hospital per-case or per-diem rates.
- Of the 42 states and the District of Columbia that reported capitated Medicaid arrangements, 16 states and the District of Columbia made explicit Medicaid GME payments to teaching hospitals or teaching programs. Seventeen other states included the payments in managed care organizations' capitated rates. Teaching hospitals were the recipients of most states' GME payments, although, in Oklahoma and Tennessee, medical schools were the only training programs to receive them directly under managed care.
- While medical residents were predominantly eligible for Medicaid GME payments, nurses and other health professions students were eligible under managed care (or there was no distinction among the health professions) in eight states and the District of Columbia.

- Of the five states (and Puerto Rico) that did not provide Medicaid GME support, only Illinois and Puerto Rico had significant residency programs. Alaska, Idaho, and Montana, which belonged to the Washington-Wyoming-Alaska-Montana-Idaho undergraduate and graduate medical education program centered at the University of Washington, did not have academic health centers. South Dakota had one but did not report any GME payments to its teaching hospital or medical school.¹⁴

Examples of Innovation

Some states have experimented with GME funds in order to achieve certain goals. At an April 2001 state health officials forum held by NCSL under the sponsorship of HRSA,¹⁵ states that have taken the initiative in Medicaid GME reported on their progress:

- Since 1997, Michigan has had three pools: one that pays teaching hospitals at 1995 levels, one that rewards them for their proportions of primary care residents and indigent patients, and one for “innovations” that gives grants to GME consortia made up of a university, a hospital, and a health maintenance organization (HMO). On July 1, 2001, the state plans to implement a new formula for both the historical (1995 base) and primary care pools. The new formula will pay hospitals based on the number of full-time employees in training. It will be weighted both for Medicaid utilization and for performance factors (that physicians participate in Michigan's Medicaid program after completing their residency and that they receive board certification).¹⁶
- Also since 1997, Minnesota has operated a Medical Education and Research Cost Fund—called “MERC”—for clinical training costs. It is currently funded by general revenues; the state's tobacco settlement; and federal Medicaid matching funds, which are clearly earmarked for medical education. It supports the unrecovered costs of clinical training for medical students and residents, dental students and residents, pharmacists, chiropractors, advanced practice nurses, and physician assistants. It targets its funds to cover a specific percentage of clinical training costs at sites that provide care to the Medicaid population. As part of MERC, the state instituted a managed Medicaid carveout pool that became effective in 2000 but has yet to be extended to the entire state.¹⁷
- New York has a GME Reform Incentive Pool that has the following goals: to reduce the number of physician trainees, to increase the number of primary care

physicians, and to promote residency training in ambulatory sites. Distribution of the funds, which may be to individual hospitals or a consortium of hospitals, is based on performance in meeting the goals (for example, number of residents, primary-care training, and number of ambulatory-care sites).¹⁸

- Tennessee eliminated Medicaid GME funding in January 1995, when it adopted TennCare, its Medicaid managed care program. After a study group had evaluated TennCare's role in funding GME and developed a methodology, the state restored its GME funding in 1996, retroactive to July 1995. Under the new model (subject to a five-year phase-in), the goals are to increase the training of TennCare physicians, retain them in underserved areas, and direct GME money to nonhospital settings. Payments go to medical schools, of which there are four in the state, rather than to teaching hospitals. Each medical school has its own primary care target and is subject to a cutback in funding if it fails to meet it. There is a set-aside for stipends to physicians who stay in the state.¹⁹
- Texas has had discretionary programs to encourage practice in rural areas and primary care training since 1979. In addition to its graduate medical residency program, it has family practice and primary care residency programs, plus a resident physician compensation program, which supports residency training in teaching hospitals. Its GME program centers on eight medical schools and 11 independent primary care residencies. In terms of Medicaid, the state opted in 1997 for a Medicaid carveout of GME funds from HMO capitation rates and directed the funds to teaching hospitals for primary care residency training.²⁰
- Based on a health professions education cost study completed in 1996, Utah created the Medical Education Council in 1997 to address the stabilization of health professions education funding and to correlate the financing with workforce goals. The council's criteria include geographic balance, training setting, encouragement of multidisciplinary education, and stable funding for accredited programs. The council would like to see both Medicaid and Medicare funds paid to it. While the council has a Medicare waiver application in its final stages with the Health Care Financing Administration (HCFA), it has made no progress on amending the state's Medicaid plan. Prior to last year, when the Utah legislature approved \$500,000 to stabilize a family

practice training program, the state had not provided any funds for GME training.²¹

Adverse Effects of Managed Care and the BBA

The growth of managed care in state Medicaid programs is assumed to have a negative effect on Medicaid GME payments. From 1996 to 2000, the Medicaid managed care population increased from 13.3 million to 18.8 million, or from 40.1 percent to 55.8 percent of the total Medicaid population.²² Even if states pay managed care organizations for GME, the organizations "are not bound to distribute these dollars to hospitals with GME programs or to provide GME themselves."²³

Moreover, the BBA may have had a chilling effect on Medicaid GME because of a relationship between Medicaid GME and Medicaid disproportionate-share hospital (DSH) payments. The BBA reduced Medicaid DSH payments by \$10.4 billion over five years, a reduction that was partly restored by the BBRA and BIPA. Hospitals may have looked at Medicaid GME as a trade-off for reduced Medicaid DSH payments, much the same way in which they see a trade-off between the Medicare DSH and IME adjustments.

AN EXAMINATION OF FEDERAL REFORM PROPOSALS

Of the four major approaches to reforming Medicare GME, tweaking the existing program seems to have been the pathway of choice. However, the other three have generated considerable discussion.

Minor Changes— Tinkering around the Edges

Various changes have been made in the GME program since it was initiated. According to Richard Knapp, Ph.D., AAMC vice president,

six policy issues have dominated the Medicare DGME debate since the enactment of COBRA: payments to nonhospital entities, the duration of training for which payment is made, the limitation of payments to certain types or a defined number of residents, differential payments by specialty, payments directly to programs, and limits on the geographic variation in per-resident payments.

In his view, only limits on geographic variation "have been changed substantially."²⁴ The IME, as indicated, has undergone significant downsizing: from 1983's 11.59 percent to today's 6.5 percent.

A Major Change— Folding DGME into IME

For the last two years, the Medicare Payment Advisory Commission (MedPAC) has advocated replacing the existing GME system with a new approach. In 1999, the commission proposed that DGME and IME be combined into a single adjustment to DRG rates, rather than having DGME be a pass-through (albeit subject to restrictions) and having IME be an adjustment to the DRG. It referred to the adjustment as an “enhanced patient care” payment, a term that was later dropped. It also advised revising certain aspects of Medicare case-pricing, in order to achieve better correlation between expected inpatient costs and actual inpatient payments per case across various types of hospitals.²⁵

In its June 2000 *Report to the Congress*, the commission reiterated its positions on what it now called “a teaching adjustment” and on case-pricing. It provided an analysis of its 1999 recommendations and concluded:

The Congress should fold inpatient DGME costs into PPS payment rates through a revised teaching hospital adjustment. The new adjustment should be set such that the subsidy provided to teaching hospitals continues as under current long-run policy. This recommendation also should be implemented with a reasonable transition to limit the impact on hospitals of substantial changes in Medicare payments and to ensure that beneficiaries have continued access to the services that teaching hospitals provide.²⁶

Joseph P. Newhouse and Gail R. Wilensky, two of the MedPAC principals involved in the conception of the commission’s proposal, justify merging DGME and IME because they see “no economic reason for Medicare to distinguish” between them.

Both types of cost represent the additional cost of the patient care provided at teaching hospitals. Thus, the direct payments can be treated in the same fashion as indirect costs. Doing so would resolve one anomaly of the current payment method: direct GME costs are reimbursed at the 1984 level of costs per resident, trended forward by the change in the Consumer Price Index. Reimbursement has been held at 1984 costs plus inflation to preclude hospitals from simply moving other costs to those that are now passed through. As measured by Medicare, however, hospitals had very different levels of costs per resident in 1984, in part because some hospitals had more volunteer faculty (and thus lower costs) and in part because of differences in hospitals’ accounting practices in 1984.²⁷

Entitlement to Authorization— Taking the CHGME Model

Following the CHGME example of subjecting GME costs to the authorization and appropriation process would, of course, mean separating them from the Medicare entitlement program. Not only would going the authorization-appropriation route mean assigning the significant GME dollars to different congressional committees but it would also mean assigning the program to a different administrative unit at the Department of Health and Human Services (DHHS). The House Ways and Means Committee and the Senate Finance Committee now have Medicare GME in their jurisdictions, as does HCFA at DHHS. CHGME falls under the House Energy and Commerce Committee and Appropriations Committee, as well as under the Senate Health, Education, Labor, and Pension Committee and Appropriations Committee. While DHHS’ HCFA has Medicare GME, HRSA is in charge of CHGME.

While the National Bipartisan Commission on the Future of Medicare did not come to a final vote on its recommendations, one of its pending proposals was to convert DGME to a program in which its funds would be appropriated, while retaining IME as an HI Trust Fund expenditure. Objections were raised that doing so would make funding of DGME unpredictable and capricious, forcing it to compete with other discretionary health programs.

A Revenue Initiative— Creating an All-Payer Fund

While the idea of an all-payer fund goes back to a provision in former President Clinton’s Health Security Act proposal, Sen. Daniel Patrick Moynihan (D-N.Y.), who retired at the end of the 106th Congress, carried it forward. Along with Rep. Nita M. Lowey (R-N.Y.), he cosponsored the Medical Education Trust Fund Act of 1999, to establish separate Medicare and non-Medicare trust funds for teaching hospitals and to create a medical school account. If enacted, the Moynihan-Lowey approach would have levied a 1.5 percent tax on health insurance premiums and administrative services as well as drawn on 5 percent of federal Medicaid spending for inpatient services to establish the non-Medicare account. Sen. Jack Reed (D-R.I.) has introduced the legislation in the 107th Congress, joined by the two Democratic senators of New York, Sens. Hillary Rodham Clinton and Charles Schumer, as co-sponsors.

The rationale for an all-payer fund is that “medical education is a public good and that, because everyone benefits from a well-trained workforce, everyone should pay,” as Newhouse and Wilensky describe it. They continue:

This notion is very different from economists’ view of a public good. Loosely speaking, economists view a good as being public if the benefits are equally available to everyone—that is, if consumers cannot be excluded from consumption (for example, the light from a lighthouse).²⁸

According to COGME’s Fifteenth Report, the Pew Health Professions Commission, Commonwealth Fund, and associations representing major GME stakeholders that signed a 1997 consensus agreement²⁹ back some sort of all-payer fund. However, given the lack of Republican support to date for a new tax to mandate that private insurers and health plans contribute to GME, the outlook of such an initiative looks dim in the 107th Congress.

SOME KEY QUESTIONS

The meeting will raise and address various questions about GME:

- How active should the federal and state governments be in influencing the health workforce? Why should public insurance or general revenue funds be used to fund the training of physicians and certain other practitioners?
- To what extent does federal and state GME spending in the United States influence the numbers of physicians (and perhaps other practitioners)? The proportion of generalists to specialists? The proportion of U.S. graduates to IMGs? The distribution of practitioners in different geographic areas?
- What do variations in Medicare GME payments—DGME and IME—mean in terms of the physician workforce? The distribution of practitioners in different areas?
- According to the report that accompanied the legislation that created the Medicare program, the program should pay for GME “until the community undertakes to bear such education costs in some other way.” Does this statement have the same bearing that it had in the mid-1960s? According to the report that accompanied the legislation that established the Medicare inpatient PPS program, IME is “a proxy to account for a number of factors that may legitimately increase costs in teaching hospitals.” What bearing does this statement have today?
- Given changes in health service delivery and financing—especially the shift from inpatient to outpatient services—should teaching hospitals still be the major recipients of GME funds? Is the HI Trust Fund still the appropriate payer of GME costs?
- If GME were moved to ambulatory settings, what would be the best way of structuring it?
- Would the federal authorization and appropriation process be a more accountable way of funding Medicare GME than the Medicare entitlement?
- What lessons do states that have experimented with Medicaid GME have for federal policymakers responsible for Medicare GME policy?
- Should states support Medicaid GME? Why or why not? If so, at what financial level? How effective are current Medicaid GME programs in helping states meet their health professions workforce needs? How flexible should DHHS be in permitting states to experiment with Medicaid (and Medicare) GME dollars?
- Does the political will exist to reform GME?
- Of the reform proposals on the table, which is the most likely to gain consensus?

THE FORUM SESSION

This Forum session will look at the present strengths and weakness of GME policy, at both the federal and state levels, and proposals for reforming the federal GME system. It will provide background on Medicare GME spending in selected states. The meeting will also feature discussion of Medicaid GME issues and the impact of state policies both on state workforce concerns and on federal GME reform.

Sheila P. Burke, Under Secretary for American Museums and National Programs at the Smithsonian Institution and a newly appointed member of MedPAC, will moderate the meeting. She chairs NHPF’s Technical Advisory Group on Private Markets, which provides guidance to the Forum on meeting and site visit programs. She has been at the Smithsonian for a year, after having served as executive dean of the John F. Kennedy School of Government, Harvard University, since 1997. From 1986 to 1996, she was the chief of staff to then Senate Majority Leader Robert Dole and was elected to serve as secretary of the Senate in 1995. Earlier, she was deputy staff director (1982 to 1985) and a professional staff member (1979 to 1982) of the Senate Committee on Finance. Trained in nursing at the

baccalaureate level, she has an M.P.A. degree from Harvard University.

Thomas R. Oliver, Ph.D., and Atul Grover, M.D., will describe the status of Medicare GME payments in selected states. An associate professor of health policy and management in the School of Hygiene and Public Health at Johns Hopkins University, Oliver has published extensively on health policy innovation and system reform at the federal, state, and community levels. He received an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation in 1993. He is a member of a study panel on Medicare management and Governance convened by the National Academy of Social Insurance. He received his doctoral degree in political science from the University of North Carolina.

Grover is a post-doctoral National Research Service Award fellow and Ph.D. candidate in health care policy in the School of Hygiene and Public Health at Johns Hopkins. A graduate of the George Washington University School of Medicine, where he was a National Health Service Corps scholar, he completed residency training at the University of California at San Francisco. He is a board-certified specialist in internal medicine. His research interests are medical education and primary care.

Edward S. Salsberg will review state Medicaid and discretionary GME programs and their relationship to state workforce goals. He is the director of the Center for Health Workforce Studies, which he founded in 1996, and a faculty member at the School of Public Health at the State University of New York at Albany. Co-author of numerous reports and papers on the health workforce, he is a member of the steering committee of the National Academy for State Health Policy and of the U.S. delegation to the International Physician Workforce Conference. From 1984 to 1996, he was bureau director at the New York State Department of Health, where he specialized in health workforce and primary care policies and programs. He has a master's degree in public administration from New York University's Wagner School.

Barbara O. Wynn will comment on various factors that affect GME payments, such as individual hospital decisions regarding faculty costs, overhead expenses, faculty practice plans, and volunteer and salaried faculty. She will also address provisions in the BBRA and BIPA that have narrowed the variation in DGME payments and add her perspective on issues raised by the other presenters. She has been a senior health policy analyst at the RAND Corporation since 1999. Previ-

ously, she was with HCFA for 24 years. Her positions included director of hospital payment policy, deputy director and acting director of the Bureau of Policy Development, and director of the Plan and Provider Purchasing Policy Group. She guided the development of regulatory policies implementing major provisions of the Balanced Budget Act, including those affecting payments for graduate medical education.

ENDNOTES

1. "GME is clinical training in an approved residency program following graduation from schools of medicine, osteopathy, dentistry, and podiatry. The training is required for certification in a specialty and is approved by a non-governmental accrediting organization for the specialty. The residency program varies in length depending upon the specialty." Council on Graduate Medical Education (COGME), *Financing Graduate Medical Education in a Changing Health Care Environment, Fifteenth Report*, December 2000, 1.
2. Traditionally known as direct medical education (DME) costs, the term has evolved to DGME, in part due to the former Prospective Payment Assessment Commission's (ProPAC's) urging. DME more commonly refers to "durable medical equipment."
3. Tim M. Henderson, *Funding of Graduate Medical Education by State Medicaid Programs*, a survey conducted by the National Conference of State Legislatures (NCSL) for the Association of American Medical Colleges (AAMC), April 1999, 8.
4. Marilyn Biviano, "National Center for Health Workforce Information and Analysis: Research Agenda," slide presentation for the NCSL Forum for State Health Policy Leadership, Lake Tahoe, California, April 26-27, 2001, 23.
5. American Medical Association, "Physician Characteristics and Distribution in the U.S.," Chicago, 15.
6. Cited by Richard Knapp, "Complexity and Uncertainty in Financing Graduate Medical Education," unpublished AAMC paper based on a presentation made at the American Board of Internal Medicine Summer Conference in Vail, Colorado, August 2, 1999, 1.
7. Ralph W. Muller, "Making the Case for Public Support of Teaching Hospitals and Medical Schools," *Academic Medicine*, 76, no. 2 (February 2001), 202-207.
8. COGME, *Financing Graduate Medical Education*, 17.
9. COGME, *Financing Graduate Medical Education*, 3.
10. ProPAC and the Physician Payment Review Commission have since merged to form the Medicare Payment Advisory Commission, or MedPAC.

11. Thomas R. Oliver, Atul Grover, and Philip R. Lee, "Variations in Medicare Payments for Graduate Medical Education in California and Other States," paper prepared for the California HealthCare Foundation, April 2001.
12. Michael Hash, comments submitted to the California HealthCare Foundation in a review of the Oliver-Grover-Lee paper.
13. COGME, *Financing Graduate Medical Education*, 60.
14. Tim M. Henderson, "Medicaid's Role in Financing Graduate Medical Education," *Health Affairs*, 19, no. 1 (January/February 2000): 223-225.
15. Forum for State Health Policy Leadership, Lake Tahoe, California, April 26-27, 2001.
16. Denise Holmes, director, Plan Administration and Customer Services Bureau, Michigan Department of Community Health, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 26.
17. Diane Rydrych, coordinator, Medical Economics Program, Minnesota Department of Health, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 27.
18. Ralph Bielefeldt, Bureau of Health Economics, New York State Department of Health, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 27.
19. John Tighe, deputy to the governor for health policy, Tennessee Department of Finance and Administration, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 26.
20. Stacey Silverman, director, Medical Education Programs, Texas Higher Education Coordinating Board, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 26.
21. David Squire, financial officer, Utah Medical Education Council, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, April 27.
22. Health Care Financing Administration, "Penetration Rates from 1996-2000: National Summary Table"; accessed May 25, 2001, at <http://www.hcfa.gov>.
23. Henderson, "Medicaid's Role," 221-222.
24. Knapp, "Complexity and Uncertainty," 3.
25. MedPAC, *Report to the Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals*, Washington, D.C., August 1999.
26. MedPAC, *Report to the Congress: Selected Medicare Issues*, Washington, D.C., June 2000, 52.
27. Joseph P. Newhouse and Gail R. Wilensky, "Paying for Graduate Medical Education: The Debate Goes On," *Health Affairs*, 20, no. 2 (March/April 2001): 142-43.
28. Newhouse and Wilensky, "Paying for Graduate Medical Education," 139-40.
29. American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Centers, AAMC, and National Medical Association.