Memorandum

Date JUL 28 1994

From Michael Mangano for June Gibbs Brown
Inspector General

Subject A Study of Graduate Medical Education Costs (A-09-93-00096)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final audit report entitled, "A Study of Graduate Medical Education Costs." The report analyzes hospital graduate medical education (GME) costs during the first 5 years of Medicare's prospective payment system, which began October 1, 1983. Our report is intended to assist health care policymakers in their review and formulation of GME payment policy. We found that historical GME costs increased much faster than leading economic indices and that average costs per resident varied widely among hospitals. For the 928 hospitals reviewed, GME costs increased from $2.837 billion to $3.752 billion, over 32 percent.

The implementation of hospital specific prospective payments for GME, as well as the recent enactment of the Omnibus Budget Reconciliation Act of 1993, have limited cost increases but the Administration has proposed further reforms. The Administration recently submitted its Health Security Act of 1993 to the Congress. The proposed legislation includes reforms which could resolve many of our concerns, especially in regards to Medicare's subsidy of surplus physician specialists. The legislation contains provisions that would restrict the number of positions and types of specialty training to be funded. The legislation also addresses the wide variation in average per resident costs among hospitals by proposing that payments be based on national average costs.

With the end of physician shortages in many specialties, we see an opportunity for Medicare to cut back its subsidy of GME costs. If the GME provisions included in the reforms do not pass as proposed, we are recommending that the Health Care Financing Administration (HCFA) reevaluate Medicare's current policy of paying GME costs for all physician specialties. In its reevaluation, HCFA should consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME costs for specialties with a surplus of physicians.

The HCFA agreed with the conclusions in our report. The HCFA also indicated that if health care reform is not enacted, the report recommendation would be considered when evaluating Medicare's GME payment policies.

We would appreciate your views and the status of any further action taken or contemplated on our recommendation within the next 60 days. If you have any questions or further comments, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-09-93-00096 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A STUDY OF GRADUATE MEDICAL EDUCATION COSTS

JUNE GIBBS BROWN
Inspector General

JULY 1994
A-09-93-00096

SUMMARY

We performed an analysis of graduate medical education (GME) costs to assist health care policymakers in their review and formulation of teaching hospital payment policy related to the training of residents. We reviewed the history of Medicare's financing of the GME program. We analyzed changes in total reported GME costs and the allowable portion of those costs for 928 hospitals over a 5-year period beginning October 1, 1983, the start of the hospital prospective payment system (PPS). We also analyzed the GME costs that would be permitted under the new Medicare limit methodology that became effective July 1, 1985. In addition, we reviewed proposed reforms to the current GME payment methodology and considered Medicare's future financing alternatives in regard to GME costs.

When the Medicare program began in the 1960's, the country had a shortage of physicians, along with little community financial support for alleviating the shortage. Even though Medicare was a program for the aged and disabled, its funds were used to train more physicians for the benefit of the Nation as a whole. Medicare shared in the cost of GME training programs for physician interns and residents (I&R) by reimbursing hospitals on a reasonable cost basis.

In 1989, the Health Care Financing Administration (HCFA) issued regulations to limit Medicare's share of hospitals' GME costs. Under the new methodology, an average cost per resident is established for each hospital, using its GME costs during a base period. The average cost is multiplied by the number of I&Rs to arrive at allowable GME costs. The average cost per resident was updated annually for changes in the Consumer Price Index for All Urban Consumers (CPI-U) until Fiscal Year (FY) 1994 for most physician specialties. Although HCFA issued regulations on these limits, it had been, until recently, unable to enforce them because of hospital lawsuits.

Our analysis found that total reported GME costs rose much faster than leading economic indices. During the audit period, GME costs for the 928 hospitals we reviewed escalated from $2.837 billion to $3.752 billion, an increase of 32.3 percent. The yearly increases averaged approximately 8.1 percent and were, on the average, more than twice the increases for the CPI-U, the Hospital Market Basket Index, and the PPS update factor. We also found wide variations in the average costs per resident during the periods reviewed.

Medicare will be spared from these large cost increases because of the new Medicare limits. As discussed above, the new methodology limited cost increases to changes in the CPI-U. It also reduced the variability of average costs per resident to some degree, although we found that wide variations continued to exist.

While the new limits will bring Medicare GME costs under better control than the previous system, both the current and former Administrations, as well as the Physician

Payment Review Commission (PPRC), have proposed further reforms. The proposed reforms differ but share some similarities in that they would decrease variations in payments to hospitals, encourage the training of more primary care physicians, and reduce program outlays. In addition, the Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1993 which generally eliminated cost of living increases for GME payments, except for primary care, obstetric and gynecology residents, for FYs 1994 and 1995.

The Administration's current proposal for a comprehensive reform of the Nation's health care system may resolve many of the concerns regarding GME. However, the political debate on the reforms is just beginning and it may be sometime before the reforms are enacted.

Today, the physician supply and Medicare financial situations are remarkably different than they were in the 1960's. The overall physician shortage has generally been resolved. However, Medicare finances have not fared as well. The once sound trust fund has deteriorated to the point where it may well go bankrupt in a few years unless dramatic changes are made soon. After years of investing in physician education, Medicare now has a chance to scale back GME subsidies for many physician specialties. With the financial difficulties facing Medicare, it can ill afford to be the primary financial support for educational costs associated with surplus physician specialists.

If the proposed changes to GME that are contained in the Administration's health care reform plan are not enacted, we recommend that HCFA reevaluate Medicare's policy of paying GME costs for all specialties. As part of this reevaluation, we recommend that HCFA consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians.

The HCFA agreed with the conclusions in our report. The HCFA also indicated that if health care reform is not enacted, the report recommendation would be considered when evaluating Medicare's GME payment policies.

Abbreviations

ACN	Audit Control Number
CPI-U	Consumer Price Index for All Urban Consumers
DRG	Diagnosis Related Group
FI	Fiscal Intermediary
FTE	Full-Time Equivalent
FY	Fiscal Year
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCRIS	Hospital Cost Report Information System
HHS	Department of Health and Human Services
I&R	Interns and Residents
IME	Indirect Medical Education
OAS	Office of Audit Services
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Prospective Payment System

When the Medicare program began in 1965, the Congress stipulated that hospitals were to be reimbursed their actual costs for services provided to program enrollees. However, in 1983 the Congress made a dramatic change in payment policy. The reform provided that hospitals would be reimbursed for most inpatient costs using a PPS. The new system was designed to control escalating inpatient operating costs by creating an incentive for hospitals to operate in a cost-effective manner. Hospitals would be paid a fixed amount per discharge depending on how a patient was classified within a diagnosis related group (DRG). A hospital's profitability would depend on how its actual costs to treat a patient compared to the preestablished fixed payment.

At the time PPS was established, physician training costs were excluded from the calculation of payment rates because the costs were not considered "operating costs." The Social Security Act defines operating costs to include all routine, ancillary service, and special care unit operating costs. Physician training costs were separately "passed-through" and paid on a reasonable cost basis. The reimbursement methodology for physician training costs has since been changed, with the imposition of new Medicare limits effective July 1, 1985.

Origins of Medicare Financing

In the 1950's and early 1960's, there was general concern that the Nation did not have enough physicians to serve the public. During this period, hospitals bore the cost of educating physicians, providing residents with small salaries, plus room and board. When the Medicare program was established, the Congress believed that educational programs contributed to the quality of care and were necessary to meet community needs for trained personnel.

Although Medicare was intended to be an insurance program for only the aged and disabled and not for all citizens, the Congress decided that Medicare should participate in educating physicians until communities shouldered the costs in some other fashion. Hence, it created Medicare GME funding for teaching hospitals.

The hoped for financial support from communities never materialized to any significant extent. The Federal Government continues to be the largest explicit financing source for GME through the Medicare program and through smaller programs in the Veterans Administration and Department of Defense hospitals.

Medicare Payments for Medical Education Activities

The Medicare program provides funding for medical education activities in three ways. First, payments are made to hospitals for Medicare's share of direct GME costs. Direct GME costs include payments for salaries and fringe benefits for I&Rs, teaching physicians' time spent supervising I&Rs in patient care services not billed on a reasonable charge basis, and allocable hospital indirect costs. Medicare payments for direct GME totaled about $1.1 billion during FY 1991.

Second, Medicare makes indirect medical education (IME) payments to teaching hospitals. These payments are intended to compensate hospitals for the perceived higher costs they incur because of the involvement of I&Rs in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The perceived higher costs include, for example, added costs from an increased number of tests ordered by I&Rs or faculty for instructional purposes as compared to the number of tests that would normally be ordered by more experienced physicians. Medicare payments for IME totaled about $3.3 billion during FY 1991.

Third, Medicare makes payments directly to physicians for services in which they involve I&Rs. To receive these payments, the physician must qualify as an "attending physician" on the same basis as if the physician had personally furnished the service. While no data are available on these types of payments, it has been estimated that annual faculty practice plan billings (which include billings for all services regardless of the involvement of I&Rs) under Medicare ranged between $375 million and $750 million.

Change in GME Payment Methodology

As discussed previously, the Medicare program policy had been to pay hospitals for GME costs on a "pass-through" basis. Whatever allowable GME costs hospitals incurred were shared by Medicare in direct proportion to the services received by Medicare patients.

During a 1984 hearing,[1] the Senate held discussions on Medicare's funding of medical education. The chairman of the subcommittee stated that there was a need to change the payment methodology and that he thought the funding of reasonable costs would be eliminated within 2 years. The chairman cited several reasons for his belief.

- The pressure to reduce the Federal deficit and the impending bankruptcy of the Medicare trust fund demanded an end to the open-ended subsidy.

- Third party payers were less willing to pay for GME costs, steering their members to less costly nonteaching hospitals.

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[1] "Medical Education Funding by Medicare," Hearing Before the Subcommittee on Health of the Committee on Finance, Senate Hearing 98-1264, dated October 1, 1984.

- Direct and indirect subsidies had produced a substantial surplus of physicians.

In addition to the congressional interest, HCFA focused its attention on GME costs. On July 5, 1985, HCFA published a final rule in the Federal Register which imposed a 1-year limit on GME costs for cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986. The rule required hospitals to use the lesser of their allowable costs for the period or costs reported during a base period (PPS-1) when computing reimbursable costs.

The HCFA commented that the advent of PPS, the projected surplus of physicians, and the rising costs of medical education were factors in their consideration of payment methodologies. The HCFA stated that its specific purpose was to avoid paying costs that were unnecessary in the efficient delivery of health care services to Medicare beneficiaries.

The HCFA believed that it was time for hospitals to realize that they could not continue to expand their educational programs under the assumption that there would be virtually unlimited funding from the Medicare program. Medicare's policy of basing payments on 100 percent of reasonable costs was not considered an incentive for hospitals to hold down their costs. The HCFA also believed that, in its original legislation, the Congress did not intend to share in all direct costs indefinitely. Instead, the intent was for Medicare to share in the costs until the community began to bear such costs in some other way.

The HCFA commented that while there may have been a shortage of physicians in 1965, there was now a surplus projected to continue into the future. The surplus of physicians was seen as a clear indication that a portion of GME costs was not necessary. The Medicare program was thought to be paying for unnecessary training costs since the supply of physicians was abundant.

While HCFA's July 5, 1985 final rule provided details on the reasons for changing Medicare's methodology for determining allowable costs, the rule was subsequently nullified when more permanent legislation was enacted. With the enactment of section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), GME payment methodology was changed. On September 29, 1989, HCFA published a final rule in the Federal Register to implement the changes. While the methodology became effective October 30, 1989, the changes apply retroactively to cost reporting periods beginning on or after July 1, 1985.

In order to implement the new Medicare limit methodology, fiscal intermediaries (FI) were required to perform special audits to establish each teaching hospital's average cost per resident. The average amounts were based on costs reported during a base year, generally the first year of PPS.

The FIs were also required to determine the weighted average number of full-time equivalent (FTE) I&Rs. Special weighting factors related to the length of residency and the number of residents from foreign medical schools were involved. Total allowable costs for cost reporting periods beginning subsequent to June 30, 1985 will be calculated by multiplying the average cost per resident times the number of FTE I&Rs. Average costs per resident for periods subsequent to the base period will be adjusted for changes in the CPI-U until FY 1994, at which time a freeze has been imposed on the CPI-U updates for most physician specialties. Medicare's share of the total allowable costs will be based on the ratio of Medicare days to total inpatient days.

While hospitals are currently using the new methodology[2] to report costs, GME cost settlements were suspended until more recently for cost reporting periods beginning on or after July 1, 1985. The HCFA had been stalled in its efforts to make cost settlements due to litigation by the hospital industry on the application of the methodology to prior periods. In a July 17, 1992 decision, the United States (U.S.) District Court for the District of Columbia ruled that HCFA had no authority to reaudit base year GME costs to determine hospital per resident amounts. However, in a March 9, 1993 decision, the U.S. Court of Appeals for the District of Columbia Circuit upheld HCFA's method of auditing GME costs. The HCFA recently notified FIs to perform final settlements on all suspended cost reports.

SCOPE

The objectives of our review were to:

- analyze changes in total reported GME costs (including both allowable and unallowable portions) during the first 5 PPS years,
- study the allowable portion of the total reported GME costs for the 5-year period,
- analyze GME costs under the new Medicare limit methodology that became effective on July 1, 1985,
- review the Administration's proposed reforms to the current GME payment methodology, and
- consider the need for Medicare to continue financing GME and possible changes in Medicare reimbursement methodologies.

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[2] The OIG issued a final report (A-06-92-00020) to HCFA on April 29, 1994, pointing out two flaws in the new methodology. The report recommends that HCFA revise regulations and seek legislative amendments to correct these flaws which would save Medicare about $157 million per year.

Hospitals included in our review were selected from HCFA's Hospital Cost Report Information System (HCRIS). The HCRIS is a national database of financial and statistical information extracted from hospital cost reports. The reports are submitted annually to FIs which process and review the data. The FIs submit hospital cost report data to HCFA for inclusion in HCRIS.

The information contained in HCRIS is updated quarterly to reflect information from the most current version of each hospital's cost report. Since the reports may be in different stages of review at any point in time, cost report versions may vary among hospitals or even for the same hospital in different years. The different versions are (1) as submitted, (2) settled without audit, (3) settled with audit, (4) reopened, and (5) audited but not settled. Our review was based on the most current data updated through the quarter ended September 30, 1991.

We obtained HCRIS data for the first 5 PPS years. Our review included hospitals with FYs beginning between:

- October 1, 1983 and September 30, 1984 (PPS-1).
- October 1, 1984 and September 30, 1985 (PPS-2).
- October 1, 1985 and September 30, 1986 (PPS-3).
- October 1, 1986 and September 30, 1987 (PPS-4).
- October 1, 1987 and September 30, 1988 (PPS-5).

We also obtained a file from HCFA containing audited GME data submitted by FIs. The file included average costs per resident for the base period (generally PPS-1) and subsequent period FTE I&R counts. However, we found that the file was incomplete, missing FTE counts for many hospitals which we needed to calculate costs using the new Medicare limit methodology. Accordingly, we requested and obtained the missing FTE data directly from the FIs.

To ensure comparability, we excluded data for hospitals (ranging from 155 to 276 hospitals per period) which did not submit cost reports for all 5 periods under review. In addition, we excluded 12 hospitals for which we had no FI audited base year data. After these adjustments, data for 928 hospitals remained for our analytical review.

Our review did not include any verification of costs reported by hospitals. The accuracy of HCRIS cost data was the subject of a prior Office of Inspector General (OIG) audit.[3] The audit found an accuracy rate in excess of 99 percent for data elements tested and concluded that the small error rate was considered irrelevant by system users. In addition, our review did not include any verification of costs or FTE counts provided by HCFA or FIs.

Our review was made in accordance with generally accepted government auditing standards. The review was performed by the Office of Audit Services in Sacramento, California from June 1992 to June 1993.

[3] "Validation Review of the Hospital Cost Report Information System," (A-07-88-00120), dated April 30, 1990.

FINDINGS AND RECOMMENDATION

Total reported GME costs (including both the allowable and unallowable portions) for the 928 hospitals analyzed increased significantly over the 5-year period covered by our review. The yearly increases were more than twice the increases in the CPI-U, the Hospital Market Basket Index, and the PPS update factor.

Not only did the total reported GME costs increase substantially, but the allowable portion of those total costs rose as well. However, while the allowable portion increased significantly, the new Medicare limit methodology that became effective July 1, 1985 has permitted Medicare to avoid sharing in these large cost increases. As previously noted in this report, Medicare's limit was capped at a hospital's base year costs, updated for inflation.

Our analysis of the allowable portion of the total reported costs found wide variations in average costs per resident among hospitals. With the application of the new Medicare limits, the variability of average costs per resident was reduced to some degree, but wide variations in average costs continued to occur.

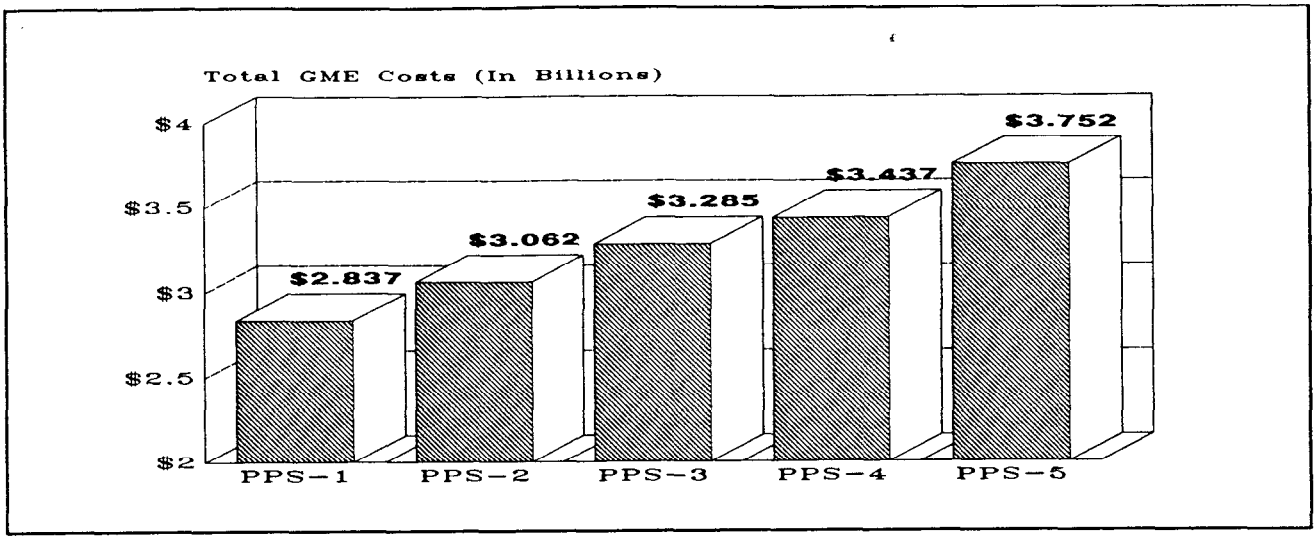
When the Medicare program was established in 1965, the Congress decided that the program should participate in the costs of training physicians to ensure an adequate supply of medical personnel. Medicare's financing of training costs may no longer be warranted as it appears a surplus of physicians is developing. While the Federal deficit grows, and while the solvency of the Medicare trust funds is in question, Medicare is subsidizing training costs for physician specialties where surpluses exist.

There have been several proposals to reform Medicare payments for GME. Past and present Administrations have proposed a change to a national average cost per resident to reduce the wide cost variations and special weighting factors to encourage an increase in the number of primary care physicians. More recently, the PPRC recommended major changes in the financing of GME costs. The current Administration has also recently proposed a comprehensive reform of the Nation's health care system.

TOTAL REPORTED GME COSTS INCREASED MORE THAN OTHER COSTS

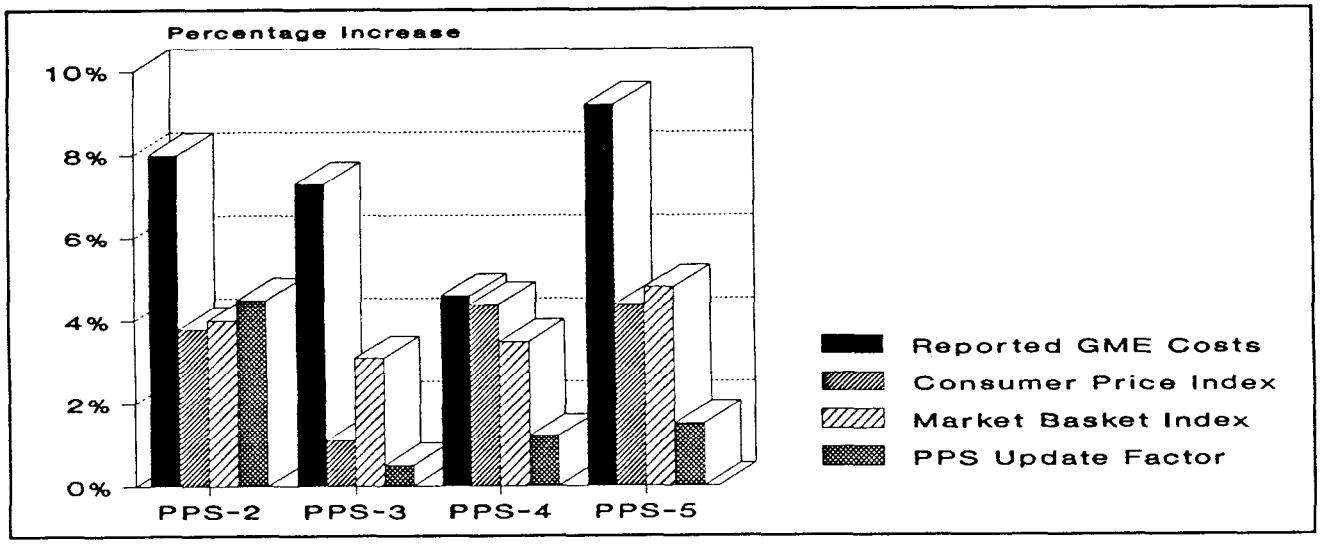
Total reported GME costs for the 928 hospitals analyzed increased significantly over the 5-year period covered by our review. During PPS-1, total reported GME costs amounted to $2.837 billion while PPS-5 costs were $3.752 billion, an increase of 32.3 percent. The yearly rates of increase ranged from a low of 4.6 percent to a high of 9.1 percent, or an average of 8.1 percent per year (32.3 percent ÷ 4 periods).

Total Reported GME Costs for 928 Hospitals
PPS-1 to PPS-5



The increases in total reported GME costs were much higher than increases in other costs. The GME costs increased, on average, over 2 times faster than changes in the CPI-U, Hospital Market Basket Index, or the annual PPS update factors.

Relative Cost Increases
PPS-2 to PPS-5



The CPI-U[4] is a measure of the average change in all consumer prices over time. During the period covered by our review, the increases in the CPI-U ranged from 1.1 percent to 4.4 percent, or an average of 3.4 percent per year (13.7 percent ÷ 4 periods), less than half the average increase of 8.1 percent for GME costs.

The Hospital Market Basket Index reflects price changes of goods and services purchased by hospitals. During the period of our review, increases in the index ranged from 3.1 percent to 4.8 percent, or an average of 3.9 percent per year (15.4 percent ÷ 4 periods), which was also much less than the average increase in GME costs.

The PPS update factor is another measure of price increases. The factor is used to adjust Medicare DRG payment rates. The update factor takes into account changes in the Hospital Market Basket Index, as well as changes in hospital productivity, technological advances, quality of care, and long term cost-effectiveness of services. During our review period, the update factor ranged from 0.5 percent to 4.5 percent, or an average of 1.9 percent per year (7.7 percent ÷ 4 periods).

ALLOWABLE PORTION OF TOTAL REPORTED GME COSTS ALSO ROSE

Since the inception of the program, Medicare has shared in the allowable portion of reasonable costs hospitals incurred for GME. Allowable costs, as defined by the Medicare program, do not include the portion of GME costs allocated to nursery, research, and other nonreimbursable cost centers.

Our analysis showed that the allowable portion of the total reported costs increased at rates slightly higher than the rate of increase in the total reported costs themselves. The allowable portion for the 928 hospitals included in our review amounted to $2.652 billion for PPS-1 while PPS-5 costs were $3.652 billion, an increase of 37.7 percent, compared to the 32.3 percent rise in total reported GME costs. The yearly increases for the allowable portion ranged from a low of 4.8 percent to a high of 12.5 percent, or an average of 9.4 percent per year (37.7 percent ÷ 4 periods). See Appendix A for details on allowable GME costs by hospital classification.

NEW LIMITS CAPPED MEDICARE SHARE

The new methodology, used to determine the allowable portion of GME costs of which Medicare pays a share, was applied retroactively to hospital cost reporting periods beginning on or after July 1, 1985. As such, adjustments were made to the allowable portion of

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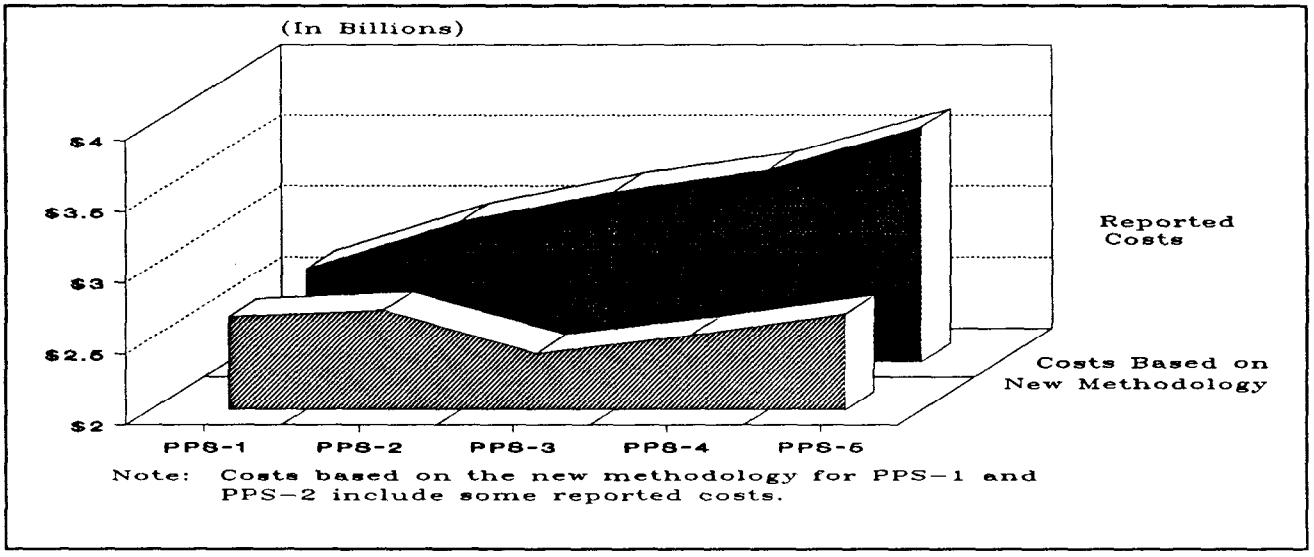
[4] The CPI-U is reported on a calendar year (CY) basis. However, the Hospital Market Basket Index and PPS update factors cover Federal FYs beginning October 1 and ending September 30. For purposes of comparison in PPS-1, which covered the period October 1, 1983 through September 30, 1984, we used the CPI-U for CY 1984. For PPS-2 comparisons, we used the CPI-U for CY 1985, and so on for PPS-3, PPS-4, and PPS-5.

reported costs discussed previously as the new methodology was implemented. While the new methodology did not apply to the PPS-1 cost reporting period and portions of PPS-2, we found a significant reduction in GME costs for subsequent periods. Compared to previously reported costs, our calculations using the new methodology indicated that the costs in which Medicare shares decreased about 24.9 percent for PPS-3, 24.5 percent for PPS-4, and 26.8 percent for PPS-5. See Appendix B for details on GME costs by hospital classification.

Increases in GME costs that will be shared by Medicare should be more moderate once the new methodology is fully implemented assuming a constant number of I&Rs. While there are still no limits on the number of FTEs under the method, increases in average costs per resident are limited to increases in the CPI-U. Based on our calculations, the costs that will be shared by Medicare will increase 5.2 percent during PPS-4 and 5.9 percent during PPS-5 using the new methodology.

GME Costs to Be Shared by Medicare

PPS-1 to PPS-5



HOSPITAL GME COSTS VARY SIGNIFICANTLY

As part of our review, we analyzed changes in average costs per resident in two ways. First, the rate of increase in the average cost based on the allowable portion of total reported costs was compared to the average cost based on the new methodology. Second, average costs per resident among individual hospitals were compared between the two methodologies.

Based on the allowable portion of total reported costs, the overall average cost per resident increased from $46,137 during PPS-1 to $57,654 during PPS-5, an increase of 25.0 percent, or an average increase of 6.3 percent (25.0 percent ÷ 4 periods). Using the new methodology, we determined that the overall average costs increased from $45,470 for PPS-3 (the first full period that required the use of the new methodology) to $49,348 for PPS-5, an increase of 8.5 percent, or an average increase of 4.3 percent (8.5 percent ÷ 2 periods). This lower rate of increase can be expected to continue since regulations limit increases to changes in the CPI-U.

Our review of individual hospitals' average cost per resident based on the allowable portion of total reported costs[5] found significant variations in all periods. See Appendix C for details on the distribution of average costs per resident based on the allowable portion of reported costs. Using the new methodology, we found that the range of average costs per resident still varied significantly, from a low of $971 to a high of $171,725. See Appendix D for details on the distribution of average costs per resident based on the new methodology.

In a 1990 report[6] to the Secretary, HCFA addressed the wide variations in GME costs. It stated that the variations were due to three factors: differences in hospital accounting practices, inaccuracies in FTE I&R counts, and actual differences in the cost of training. The HCFA concluded that the new methodology was "problematic" and recommended that per resident amounts be based upon a national average.

DECLINING NEED FOR MEDICARE INVESTMENTS IN GME

As discussed earlier, when the Medicare program was enacted, the Congress decided that Medicare would participate in the costs of educating physicians. A shortage of physicians was developing and physician training costs were considered to be a public benefit which

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[5] Extreme variations in average costs per resident using reported costs indicated that some data were questionable. We calculated costs after eliminating providers with averages less than or equal to zero or greater than or equal to $200,000 (the same cutoffs used by HCFA in its August 1990 study) and found that the effect on the overall average was negligible. Therefore, instead of eliminating hospital data using arbitrary cutoff points, we chose to leave the data in our analysis.

[6] "Report to Congress, A Recommendation for a National Per Resident Amount for Medicare Direct Graduate Medical Education Payments," dated August 20, 1990.

should be supported by tax money. However, instead of general Federal tax revenues being used, the burden fell almost entirely on Medicare tax funds.

The health care profession has been quite successful in convincing the Government to finance its general training programs, especially for physicians. We are not aware of any other professional training funded in this way and to this extent. We believe that it is time to reconsider Medicare's policy of financing GME costs. Today, surpluses of some physician specialties are developing. The possibility of having an inadequate supply of physicians (primary care physicians being a notable exception) to meet the health care needs of current and future generations no longer appears to be a threat. With a growing Federal deficit and the solvency of the Medicare trust funds in question, it does not seem entirely appropriate for Medicare to continue to subsidize the training of surplus physicians.

Physician Surplus

The supply of physicians has grown rapidly over the years. In its 1992 report,[7] the PPRC reported that the number of physicians exceeded national health care requirements. Since the early 1960's, the number of physicians more than doubled, far exceeding the growth in the overall population of the Nation. The PPRC report referred to a 1980 study done by the Graduate Medical Education National Advisory Committee, in which it predicted that a surplus of more than 135,000 physicians would occur by the year 2000. The study projected that the physician-to-patient ratio will continue to grow through the year 2020, and that, unless controlled, the supply will undermine efforts to control costs.

The PPRC's 1992 report also stated that the Nation was training too many specialists relative to the number of primary care physicians. The proportion of generalists in the Nation is much lower than other Western industrialized countries. In 1989, only about 35 percent of the physicians practiced in primary care. In contrast, generalists comprised about 63 percent of British physicians, and more than 50 percent of the physicians in Canada, Belgium, and Germany.

There is a serious imbalance in the education of primary care physicians and those in other specialties. The PPRC's 1992 report commented that since 1986, the number of residents has more than doubled in cardiology, gastroenterology, and pulmonary disease specialties. Internal medicine and pediatric residencies saw moderate growth rates of 3 percent and 5 percent, respectively. In contrast, there has been an 8 percent decline in family practice residencies. One report[8] noted that a survey of all States found that the most important problems of concern were the deficiency of primary care physicians and the excess of specialists.

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[7] "Physician Payment Review Commission, Annual Report to Congress, 1992."

[8] "Council on Graduate Medical Education, First Report of the Council, Volume 1," dated July 1, 1988.

The growth in physician specialists has contributed to the excessive growth in health care expenditures, according to the PPRC report. Payments to specialists have traditionally been higher than those to generalists for the same service since their services are more intensive and expensive. Specialists generally spend more time with patients, order more diagnostic tests, prescribe more medications, and schedule more visits than generalists.

During a 1989 hearing,[9] the chairman of the PPRC stated that the overall growth in physician supply has contributed to increased health care expenditures. Physicians have the ability to affect the demand for their services. As such, training more physicians will create more expenditures for services. It has been estimated that each physician generates about $500,000 in expenditures per year.

On June 25, 1993, the Senate passed an amendment (reference OBRA of 1993) related to the FTE weights used by hospitals to compute allowable GME costs. Recognizing the imbalance in physician specialties, the Senate set the weighting factor for a primary care residency at 1.10 and set the factor for other types of residencies at 0.70. If enacted, the factors would have reduced payments for all physician specialties with the exception of those in primary care. However, the conference agreement did not include the Senate amendment. Instead, the Congress passed OBRA of 1993 and froze per resident amounts, eliminating the annual CPI-U updates for FYs 1994 and 1995. Primary care residents and residents in obstetrics and gynecology were exempted from the freeze.

Program Viability

The Medicare program is under considerable financial stress and can no longer afford to pay for the costs of training all physicians. The Medicare Board of Trustees expressed concern about the financial viability of the trust funds over the next few years and urged the Congress to act on the problem. The Board issued separate reports on the two trust funds.

- The Board's report[10] on the Part A fund[11] concluded that: "With the magnitude of the projected actuarial deficit in the...program and the high probability that

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[9] "Fiscal Year 1990 Budget Issues Relating to Graduate Medical Education and Its Support Under the Medicare Program," Hearing Before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives Serial 101-41, dated April 11, 1989.

[10] "1993 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund," dated April 6, 1993.

[11] The Medicare Part A trust fund is funded primarily by payroll taxes on employers and employees. Payments are made from the fund for inpatient hospital care, certain inpatient care furnished in skilled nursing facilities, home health care, and hospice care.

the...trust fund will be exhausted by the turn of the century, the Trustees urge the Congress to take additional actions designed to control...program costs[12]...."

- The Board's report[13] on the Part B fund[14] stated that: "...the Trustees note with great concern the past and projected rapid growth in the cost of the program...the Trustees urge the Congress to promptly take additional actions...to control...costs...."

Considering the large budget deficit, some congressmen believe Medicare's subsidy to medical education should be reduced.[15] They have noted that during the early years of PPS, teaching hospitals had the highest profit margins of any class of hospitals.

The OIG has also found that Medicare had relatively high profit margins on Medicare payments under PPS.[16] As shown in the graph on the next page, teaching hospitals had significantly higher profit margins than nonteaching facilities on their Medicare payments.

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[12] The Congress enacted Public Law 103-66 on August 10, 1993, that will increase Part A trust fund revenues by removing the $135,000 limit on earnings subject to the Medicare tax. It is uncertain what effect the additional revenues will have on the date the trust fund is projected to go bankrupt.

[13] "1993 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund," dated April 6, 1993.

[14] The Medicare Part B trust fund is financed mostly from general tax revenues and partly from premiums on beneficiaries. Payments are made from the fund for physicians' services, outpatient hospital services, laboratory services, and certain other medical services and supplies.

[15] "Medicare Support of Medical Education," Health Affairs, Supplement 1988.

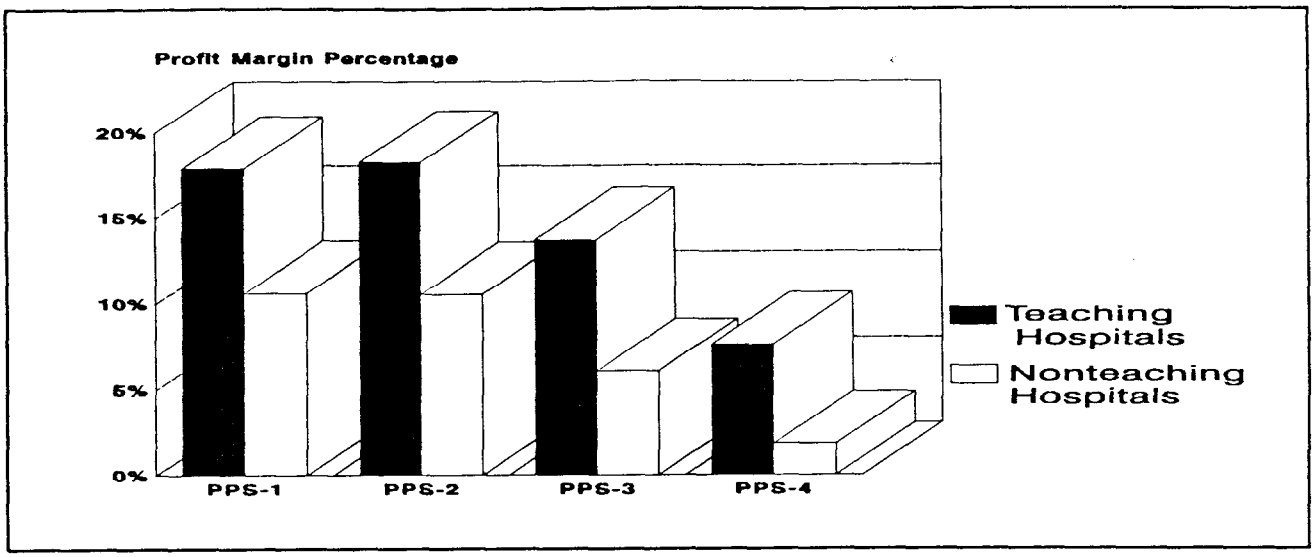
[16] "Financial Impact of the Prospective Payment System on Medicare Participating Hospitals - 1984," ACN: 09-62021, dated May 30, 1986.

"Hospitals Continue to Earn Large Profits in the Second Year of the Prospective Payment System," (A-08-87-00003), dated February 25, 1987.

"Preliminary Analysis of Hospital Profit Margins in the Third Year of the Prospective Payment System," (A-07-87-00051), dated January 25, 1988.

"Hospital Profitability in the Fourth Year of the Medicare Prospective Payment System," (A-07-88-00111), dated September 11, 1989.

Hospital Profit Margins
PPS-1 to PPS-4



PROPOSALS TO REFORM GME PAYMENTS

There have been several proposals to reform GME payments. Both the prior and current Administrations have proposed changing Medicare's payment system to a methodology based on national average salaries paid residents. The PPRC has proposed more sweeping reforms in its most recent report. Also, the current Administration just recently released its proposal to reform the Nation's health care system.

The Prior Administration's Proposals

In its FY 1991 budget proposal, the Administration proposed the use of a per resident amount derived from the national average of FY 1987 salaries paid to residents. Resident salaries are only a portion of the costs currently included in the calculation of allowable costs under the new methodology. Primary care residents were to be weighted at 180 percent of the average while nonprimary care residents would have been weighted at either 100 percent or 140 percent depending on the length of their residency. Through the use of the smaller base of resident salaries only, this budget proposal was expected to save the Medicare program about $205 million during FY 1991. However, the proposal was not adopted.

Again in its FY 1992 budget proposal, the Administration proposed that GME payments be based on the national average salary of residents. The weighting of primary care residents was increased to 240 percent of the average while the weights for nonprimary care residents, depending on the length of their residency, were left at either 100 percent or 140 percent as

in the prior year's budget proposal. This budget proposal was expected to save the Medicare program about $140 million during FY 1992. This budget proposal was also not adopted.

The Administration's Medicare budget for FY 1993 did not include any proposed changes to GME.

PPRC Proposals

In its 1993 report,[17] the PPRC concluded that substantial changes are needed in the way GME costs are financed. The PPRC recommended a new financing system "that would limit future growth in resident supply, rationalize the allocation of residency positions, and make entities sponsoring training programs more accountable to the Nation's health care needs." The recommended financing system consists of six components:

- All payers would contribute a percentage of their payments for medical care to a national pool from which GME will be financed.
- Limits on the total number of residencies to be financed from the pool would be set by the Congress.
- The distribution of residency specialties would be determined by a Federal entity.
- Decisions on which residency slots to fund within a specialty would be based on educational quality as judged by accrediting organizations.
- Prospective payments per resident would be made to either a teaching hospital, a medical school, a consortium of a medical school and several teaching hospitals, or to the training program itself.
- Payments for transitional financial relief would be made to hospitals that lose residents but still must meet essential service needs.

The PPRC's proposal is a comprehensive package of reforms. If fully implemented, it would likely result in a system of GME that would be more responsive to societal needs.

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[17] "Physician Payment Review Commission, Annual Report to Congress, 1993."

The Current Administration's Proposals

In its FY 1994 budget plan, the new Administration proposed, as had the prior Administration in FY 1992, that Medicare GME payments be based on a national average per resident amount with higher payments for primary care residents. The reform measure, expected to save $1.7 billion over 5 years, was not enacted.

Subsequently, in October 1993 the Administration proposed a comprehensive reform of the Nation's health care system. The new plan is referred to as the Health Security Act of 1993 (the Act). It includes major changes to GME that are similar to the PPRC's recommendations discussed above.

Based on the premise that all individuals benefit from the training of physicians, the Act proposes that all payers (Medicare, Medicaid, insurance companies, etc.) contribute to the costs of GME. All payers would contribute a specified percentage of their health care payments into a national pool. Payments to institutions for their GME costs would be paid from this pool.

The amount of payments to institutions for GME costs would be based on national averages of resident salaries, costs for medical supervision, and costs for other related activities. Total GME payments to institutions would be the product of the national average costs times the number of qualifying interns and residents in the particular residency program.

With regard to the issue of physician supply, the Act proposes controls over the supply and distribution of specialty residency positions. The Secretary of HHS would determine the annual number and type of residency positions by specialty that would be funded. In making determinations, the Secretary would consider the number of physicians practicing in the various specialties, the recommendations of private organizations, and the incidence of disease or disorders.

The Act includes provisions stating that at least 55 percent of the residency positions must be in primary care specialties. Under the Act, the Secretary will also determine the allocation of entering interns and residents among eligible institutions. The determination will be based on consideration of the regional distribution of approved residency programs, the quality of programs, underrepresentation of minorities, and the recommendations of private organizations.

The Administration's proposed health care reforms address our concerns. Medicare's current practice of subsidizing GME, and especially physician specialties in surplus may be resolved if the legislation passes as proposed. Additionally, the large variations in average GME costs per resident among hospitals would be eliminated through the use of a national average payment.

CONCLUSIONS AND RECOMMENDATION

The implementation of the new payment methodology limited increases in average costs per resident to changes in the CPI-U until FY 1994, after which the CPI-U update was frozen for most physician specialties. However, since average costs are based on reported costs from the base year, wide variations in GME costs will continue to occur. The Administration's FY 1994 budget proposed to base Medicare payments on a national average of resident salaries that would eliminate the variations, but the proposal was not enacted by the Congress.

In October 1993, the Administration proposed yet further changes to GME payments in its Health Security Act of 1993. This comprehensive reform of the Nation's health care system addresses many of the problems with GME. The proposal would require all payers to contribute to the cost of training physicians. The proposal would also restrict the number of positions and types of specialty training to be funded. The political debate over the proposed health care reform is just beginning. It may be sometime before legislation is enacted and compromises can be expected on many of the issues.

The original intent of Medicare's GME payment policy was to subsidize training costs during a period when there was a shortage of physicians. Today, the overall physician shortage has generally been resolved with some studies showing a growing surplus in many specialties. Despite the surplus of physicians, Medicare continues to pay the costs of educating more physicians.

Just as the end of the Cold War produced peace dividends for the Nation by allowing the Government to reduce defense spending, the general resolution of the physician shortage problem offers an opportunity dividend for Medicare. The program now has a chance to scale back GME subsidies and to effectively realize a dividend on its substantial investment since 1965. With the financial difficulties facing the Medicare trust funds, Medicare can no longer afford to pay for costs associated with physician specialties in surplus.

In the event that the proposed changes to GME in the Administration's health care reform package are not enacted, we recommend that HCFA reevaluate Medicare's policy of paying GME costs for all physician specialties. As part of this reevaluation, we recommend that HCFA consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians.

HCFA's Comments

The HCFA agreed with the conclusions in our report. It indicated that if health care reform is not enacted, the report recommendation would be considered when evaluating Medicare's GME payment policies.

The HCFA suggested that GME costs be compared with salary increases for other health care personnel. It also commented that it may be more appropriate to "fine tune" indirect medical education and disproportionate share hospital payments rather than introducing further cost shifting to cover medical education costs. In addition, HCFA believed that the savings would be less than 1 percent of total Medicare payments.

The HCFA's reply, dated May 16, 1994, is included as Appendix E.

OIG's Comments

Regarding HCFA's suggestion that a comparison be made between GME costs and the salaries of other health care personnel, the data were not comparable and, therefore, a comparison would not be relevant. Besides salary payments to I&Rs, the GME costs included payments for teaching physicians' time spent supervising I&Rs, as well as allocable hospital indirect costs.

With respect to savings, our audit report did not quantify the savings that might be realized by reducing or eliminating Medicare's investment in GME for specialties for which there is a surplus of physicians. The HCFA commented that the potential savings would be less than 1 percent of total Medicare payments. While perhaps small in relative terms, a 1 percent reduction in total Medicare payments would seem to be worthwhile in absolute dollars -- about $850 million based on Calendar Year 1992 payments.

APPENDICES

GRADUATE MEDICAL EDUCATION COSTS
BASED ON THE ALLOWABLE PORTION OF TOTAL REPORTED COSTS

	Number of Hospitals (See Note 1)	Percentage of Total Hospitals	PPS-1 Allowable GME Costs	PPS-1 Percentage of Total Allowable GME Costs	PPS-2 Allowable GME Costs	PPS-2 Percentage of Total Allowable GME Costs	PPS-3 Allowable GME Costs	PPS-3 Percentage of Total Allowable GME Costs	PPS-4 Allowable GME Costs	PPS-4 Percentage of Total Allowable GME Costs	PPS-5 Allowable GME Costs	PPS-5 Percentage of Total Allowable GME Costs
Urban Hospitals	881	94.94%	$2,609,989,430	98.41%	$2,949,767,758	98.87%	$3,145,549,215	98.49%	$3,292,735,157	98.40%	$3,593,956,507	98.41%
Rural Hospitals	47	5.06%	42,194,340	1.59%	33,627,926	1.13%	48,353,588	1.51%	53,584,255	1.60%	58,014,749	1.59%
TOTALS	928	100.00%	$2,652,183,770	100.00%	$2,983,395,684	100.00%	$3,193,902,803	100.00%	$3,346,319,412	100.00%	$3,651,971,256	100.00%
Nonprofit Hospitals	877	94.50%	$2,578,124,257	97.21%	$2,905,313,540	97.38%	$3,103,254,911	97.16%	$3,256,624,865	97.32%	$3,556,196,155	97.38%
Proprietary Hospital	51	5.50%	74,059,513	2.79%	78,082,144	2.62%	90,647,892	2.84%	89,694,547	2.68%	95,775,101	2.62%
TOTALS	928	100.00%	$2,652,183,770	100.00%	$2,983,395,684	100.00%	$3,193,902,803	100.00%	$3,346,319,412	100.00%	$3,651,971,256	100.00%
Hospital Capacity:												
Under 50 Beds	20	2.16%	$7,985,724	0.30%	$8,050,013	0.27%	$8,333,383	0.26%	$7,871,235	0.24%	$8,709,261	0.24%
50 to 99 Beds	31	3.34%	9,874,870	0.37%	9,900,739	0.33%	10,218,400	0.32%	10,213,331	0.31%	10,286,473	0.28%
100 to 249 Beds	196	21.12%	185,609,675	7.00%	208,620,011	6.99%	220,226,825	6.90%	219,666,622	6.56%	241,250,324	6.61%
250 to 399 Beds	271	29.20%	488,478,906	18.42%	519,176,257	17.40%	527,623,351	16.52%	551,142,655	16.47%	572,604,618	15.68%
Over 400 Beds	410	44.18%	1,960,234,595	73.91%	2,237,648,664	75.01%	2,427,500,844	76.00%	2,557,425,569	76.42%	2,819,120,580	77.19%
TOTALS	928	100.00%	$2,652,183,770	100.00%	$2,983,395,684	100.00%	$3,193,902,803	100.00%	$3,346,319,412	100.00%	$3,651,971,256	100.00%

Note 1: Hospital classifications (urban vs. rural, nonprofit vs. proprietary, and capacity) are based on PPS-5 Medicare cost report data.

GRADUATE MEDICAL EDUCATION COSTS
BASED ON THE NEW MEDICARE LIMIT METHODOLOGY

			PPS-2		PPS-3		PPS-4		PPS-5	
	Number of Hospitals	*Percentage of Total Hospitals*	*Adjusted GME Costs*	*Percentage of Total Adjusted GME Costs*	*Adjusted GME Costs*	*Percentage of Total Adjusted GME Costs*	*Adjusted GME Costs*	*Percentage of Total Adjusted GME Costs*	*Adjusted GME Costs*	*Percentage of Total Adjusted GME Costs*
	(See Note 1)		*(See Note 2)*							
Urban Hospitals	881	94.94%	$2,658,473,273	98.51%	$2,353,941,191	98.11%	$2,476,273,839	98.07%	$2,622,407,971	98.07%
Rural Hospitals	47	5.06%	40,262,189	1.49%	45,322,163	1.89%	48,705,823	1.93%	51,504,447	1.93%
TOTALS	928	100.00%	$2,698,735,462	100.00%	$2,399,263,354	100.00%	$2,524,979,662	100.00%	$2,673,912,418	100.00%
Nonprofit Hospitals	877	94.50%	$2,621,689,330	97.15%	$2,322,046,269	96.78%	$2,444,936,985	96.83%	$2,590,392,861	96.88%
Proprietary Hospitals	51	5.50%	77,046,132	2.85%	77,217,085	3.22%	80,042,677	3.17%	83,519,557	3.12%
TOTALS	928	100.00%	$2,698,735,462	100.00%	$2,399,263,354	100.00%	$2,524,979,662	100.00%	$2,673,912,418	100.00%
Hospital Capacity:										
Under 50 Beds	20	2.16%	$6,984,342	0.26%	$5,781,948	0.24%	$5,783,985	0.23%	$5,446,763	0.20%
50 to 99 Beds	31	3.34%	9,194,771	0.34%	9,092,817	0.38%	9,056,583	0.36%	9,270,030	0.35%
100 to 249 Beds	196	21.12%	187,122,609	6.93%	146,801,577	6.12%	150,817,372	5.97%	157,413,431	5.89%
250 to 399 Beds	271	29.20%	462,895,304	17.15%	389,303,641	16.23%	417,567,590	16.54%	433,320,295	16.20%
Over 400 Beds	410	44.18%	2,032,538,436	75.32%	1,848,283,371	77.03%	1,941,754,132	76.90%	2,068,461,899	77.36%
TOTALS	928	100.00%	$2,698,735,462	100.00%	$2,399,263,354	100.00%	$2,524,979,662	100.00%	$2,673,912,418	100.00%

Note 1: Hospital classifications (urban vs. rural, nonprofit vs. proprietary, and capacity) are based on PPS-5 Medicare cost report data.

Note 2: Costs were not adjusted for PPS-1 and part of PPS-2 since the new methodology applied only to cost reporting periods beginning on or after July 1, 1985.

DISTRIBUTION OF AVERAGE COSTS PER RESIDENT BASED ON THE ALLOWABLE PORTION OF TOTAL REPORTED COSTS

PPS-1

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Allowable GME Costs	Percentage of Total Allowable GME Costs
Less than $10,000	26	2.80%	$848,521	0.03%
$10,000 - 19,999	44	4.74%	14,553,939	0.55%
$20,000 - 29,999	123	13.26%	195,282,290	7.36%
$30,000 - 39,999	184	19.83%	444,323,224	16.75%
$40,000 - 49,999	205	22.09%	723,067,242	27.26%
$50,000 - 59,999	134	14.44%	485,792,477	18.32%
$60,000 - 69,999	84	9.05%	339,135,390	12.79%
$70,000 - 79,999	59	6.36%	267,322,641	10.08%
$80,000 - 89,999	32	3.45%	90,486,722	3.41%
$90,000 - 99,999	16	1.72%	51,158,807	1.93%
$100,000 and over	21	2.26%	40,212,517	1.52%
TOTALS	928	100.00%	$2,652,183,770	100.00%

PPS-2

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Allowable GME Costs	Percentage of Total Allowable GME Costs
Less than $10,000	40	4.31%	$40,178,216	1.35%
$10,000 - 19,999	43	4.63%	13,630,685	0.46%
$20,000 - 29,999	113	12.18%	204,468,869	6.85%
$30,000 - 39,999	153	16.49%	324,841,615	10.89%
$40,000 - 49,999	154	16.59%	491,758,571	16.48%
$50,000 - 59,999	141	15.19%	557,520,484	18.69%
$60,000 - 69,999	112	12.07%	507,110,418	17.00%
$70,000 - 79,999	59	6.36%	317,005,087	10.62%
$80,000 - 89,999	44	4.74%	191,208,296	6.41%
$90,000 - 99,999	10	1.08%	58,775,834	1.97%
$100,000 and over	59	6.36%	276,897,609	9.28%
TOTALS	928	100.00%	$2,983,395,684	100.00%

DISTRIBUTION OF AVERAGE COSTS PER RESIDENT BASED ON THE ALLOWABLE PORTION OF TOTAL REPORTED COSTS

PPS-3

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Allowable GME Costs	Percentage of Total Allowable GME Costs
Less than $10,000	40	4.31%	$38,062,223	1.19%
$10,000 - 19,999	30	3.23%	21,004,416	0.66%
$20,000 - 29,999	97	10.45%	162,410,233	5.08%
$30,000 - 39,999	170	18.32%	394,606,151	12.35%
$40,000 - 49,999	157	16.92%	398,125,672	12.47%
$50,000 - 59,999	131	14.12%	619,131,191	19.38%
$60,000 - 69,999	100	10.78%	434,625,882	13.61%
$70,000 - 79,999	68	7.33%	312,556,418	9.79%
$80,000 - 89,999	43	4.63%	291,159,387	9.12%
$90,000 - 99,999	29	3.12%	136,777,978	4.28%
$100,000 and over	63	6.79%	385,443,252	12.07%
TOTALS	928	100.00%	$3,193,902,803	100.00%

PPS-4

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Allowable GME Costs	Percentage of Total Allowable GME Costs
Less than $10,000	24	2.59%	$51,823,477	1.55%
$10,000 - 19,999	32	3.45%	14,556,868	0.43%
$20,000 - 29,999	96	10.34%	169,170,180	5.06%
$30,000 - 39,999	155	16.70%	346,480,330	10.35%
$40,000 - 49,999	153	16.49%	397,959,740	11.89%
$50,000 - 59,999	148	15.95%	626,810,497	18.73%
$60,000 - 69,999	102	10.99%	430,921,698	12.88%
$70,000 - 79,999	67	7.22%	303,548,195	9.07%
$80,000 - 89,999	66	7.11%	349,576,406	10.45%
$90,000 - 99,999	32	3.45%	230,836,495	6.90%
$100,000 and over	53	5.71%	424,635,526	12.69%
TOTALS	928	100.00%	$3,346,319,412	100.00%

DISTRIBUTION OF AVERAGE COSTS PER RESIDENT
BASED ON THE ALLOWABLE PORTION OF TOTAL REPORTED COSTS

PPS-5

Average Cost per Resident	*Number of Hospitals*	*Percentage of Total Hospitals*	*Allowable GME Costs*	*Percentage of Total Allowable GME Costs*
Less than $10,000	23	2.48%	$10,034,306	0.27%
$10,000 – 19,999	33	3.56%	15,814,701	0.43%
$20,000 – 29,999	84	9.05%	125,527,433	3.44%
$30,000 – 39,999	129	13.90%	307,496,468	8.42%
$40,000 – 49,999	136	14.65%	369,774,245	10.13%
$50,000 – 59,999	141	15.19%	546,066,759	14.95%
$60,000 – 69,999	116	12.50%	614,528,848	16.83%
$70,000 – 79,999	82	8.84%	335,021,857	9.17%
$80,000 – 89,999	55	5.93%	369,266,650	10.11%
$90,000 – 99,999	46	4.96%	321,714,681	8.81%
$100,000 and over	83	8.94%	636,725,308	17.44%
TOTALS	928	100.00%	$3,651,971,256	100.00%

DISTRIBUTION OF AVERAGE COSTS PER RESIDENT BASED ON THE NEW MEDICARE LIMIT METHODOLOGY

PPS-2

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Adjusted GME Costs (See Note 1)	Percentage of Total Adjusted GME Costs
Less than $10,000	27	2.91%	$15,133,020	0.56%
$10,000 - 19,999	39	4.20%	7,773,610	0.29%
$20,000 - 29,999	123	13.26%	224,309,262	8.31%
$30,000 - 39,999	210	22.63%	429,838,936	15.93%
$40,000 - 49,999	172	18.54%	527,592,422	19.55%
$50,000 - 59,999	130	14.01%	494,838,057	18.34%
$60,000 - 69,999	103	11.10%	422,892,737	15.67%
$70,000 - 79,999	53	5.71%	230,590,303	8.54%
$80,000 - 89,999	25	2.69%	117,145,882	4.34%
$90,000 - 99,999	7	0.75%	43,678,224	1.62%
$100,000 and over	39	4.20%	184,943,009	6.85%
TOTALS	928	100.00%	$2,698,735,462	100.00%

Note 1: Costs were not adjusted for PPS-1 and part of PPS-2 since the new methodology applied only to cost reporting periods beginning on or after July 1, 1985.

PPS-3

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Adjusted GME Costs	Percentage of Total Adjusted GME Costs
Less than $10,000	10	1.08%	$2,117,342	0.09%
$10,000 - 19,999	40	4.31%	7,705,919	0.32%
$20,000 - 29,999	118	12.72%	170,166,963	7.09%
$30,000 - 39,999	258	27.80%	501,961,358	20.92%
$40,000 - 49,999	219	23.60%	622,642,255	25.95%
$50,000 - 59,999	133	14.33%	501,540,440	20.90%
$60,000 - 69,999	90	9.70%	301,795,449	12.58%
$70,000 - 79,999	34	3.66%	133,773,664	5.58%
$80,000 - 89,999	15	1.62%	84,080,592	3.51%
$90,000 - 99,999	3	0.32%	8,952,065	0.37%
$100,000 and over	8	0.86%	64,527,307	2.69%
TOTALS	928	100.00%	$2,399,263,354	100.00%

DISTRIBUTION OF AVERAGE COSTS PER RESIDENT BASED ON THE NEW MEDICARE LIMIT METHODOLOGY

PPS-4

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Adjusted GME Costs	Percentage of Total Adjusted GME Costs
Less than $10,000	9	0.97%	$2,034,455	0.08%
$10,000 - 19,999	39	4.20%	7,641,078	0.30%
$20,000 - 29,999	97	10.45%	139,454,135	5.52%
$30,000 - 39,999	238	25.65%	481,312,327	19.06%
$40,000 - 49,999	219	23.60%	587,061,945	23.25%
$50,000 - 59,999	157	16.92%	615,245,492	24.37%
$60,000 - 69,999	93	10.02%	333,838,019	13.22%
$70,000 - 79,999	40	4.31%	150,731,921	5.97%
$80,000 - 89,999	21	2.26%	117,536,313	4.66%
$90,000 - 99,999	6	0.65%	17,711,744	0.70%
$100,000 and over	9	0.97%	72,412,233	2.87%
TOTALS	928	100.00%	$2,524,979,662	100.00%

PPS-5

Average Cost per Resident	Number of Hospitals	Percentage of Total Hospitals	Adjusted GME Costs	Percentage of Total Adjusted GME Costs
Less than $10,000	8	0.86%	$162,479	0.01%
$10,000 - 19,999	33	3.56%	9,176,095	0.34%
$20,000 - 29,999	82	8.84%	115,865,784	4.33%
$30,000 - 39,999	200	21.55%	384,270,107	14.37%
$40,000 - 49,999	246	26.51%	693,568,876	25.94%
$50,000 - 59,999	156	16.81%	599,947,243	22.44%
$60,000 - 69,999	104	11.21%	427,811,268	16.00%
$70,000 - 79,999	52	5.60%	182,710,333	6.83%
$80,000 - 89,999	27	2.91%	130,543,468	4.88%
$90,000 - 99,999	9	0.97%	38,222,218	1.43%
$100,000 and over	11	1.18%	91,634,547	3.43%
TOTALS	928	100.00%	$2,673,912,418	100.00%

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 16 1994

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "A Study of Graduate Medical Education (GME) Costs" (A-09-93-00096)

We reviewed the subject draft report which analyzed hospital GME costs during the first 5 years of Medicare's prospective payment system, which began October 1, 1983. Our specific comments are attached.

Thank you for the opportunity to review and comment on this report. Please advise us if you agree with our comments on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on the Office of Inspector General (OIG) Draft Report:
"A Study of Graduate Medical Education (GME) Costs"
(A-09-93-00096)

OIG Recommendation

In the event that the proposed changes to GME in the Administration's health care reform package are not enacted, OIG recommends that HCFA reevaluate Medicare's current policy of paying GME costs for all physician specialties. In its reevaluation, HCFA should consider submitting legislation to reduce or even possibly eliminate Medicare's investment in GME costs for specialties with a surplus of physicians.

HCFA Response

Due to the hypothetical nature of the recommendation, we can neither concur nor nonconcur at this time. We agree with the conclusions in the report. If health care reform is not enacted, we will consider the report's recommendation when evaluating Medicare's GME payment policies.

Technical Comments

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report.

- pages 7, 8, and 9 - How do GME costs compare with salary increases for other health care personnel?

Page 2

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report.

o pages 14 and 15 - The PPS margin measures only the profitability of treating Medicare patients. The total facility margin is a more appropriate measure of overall profitability. However, repeated studies of total facility margins by both HCFA and the Prospective Payment Assessment Commission have indicated that teaching hospitals have been less profitable than the average hospital. Even if teaching hospitals' PPS margins are used as evidence to suggest that HCFA is overpaying these hospitals, it may be more appropriate to "fine tune" indirect medical education and disproportionate share hospital payments rather than introducing further cost shifting to cover medical education costs.

o page 18 - It should be noted that the savings discussed in paragraph 4 are less than 1 percent of total Medicare payments.