The Evolution Of Support For Safety-Net Hospitals

Changes in the medical care marketplace are placing funding for uncompensated care and clinical education provided by safety-net hospitals at risk.

by Linda E. Fishman and James D. Bentley

PROLOGUE: Teaching hospitals hold a special place in America’s pluralistic system of health care delivery and financing. They are citadels of medical learning and institutions that care for some of our most vulnerable citizens. But they also are the places where much of the innovation that leads to medical progress is conducted. Because teaching hospitals are complex institutions that perform multiple missions, federal and state governments have woven a complex set of policies that seek to balance public and private interests.

In this paper two veterans of federal health policy making examine the rich history and current status of hospital support for financing uncompensated care and graduate medical education. Linda Fishman, who has a reputation in policy circles as a level-headed realist, is associate vice-president in the Office of Governmental Relations of the Association of American Medical Colleges (AAMC). Fishman holds two degrees from the University of Washington, where she was elected to Phi Beta Kappa. Fishman recently produced a monograph for the AAMC that is essential reading for anyone who wants to understand the complexities of Medicare’s financing of graduate medical education. James Bentley, senior vice-president of the American Hospital Association (AHA), has been instrumental in shaping federal policy as it applies to graduate medical education and hospital financing. Bentley directs the AHA’s public policy analyses as well as related activities. He holds a doctorate in medical care organization from the University of Michigan. He spent ten years at the AAMC before joining the AHA.
ABSTRACT: The federal government, mostly through the Medicare and Medicaid programs, has created and maintained a set of structural mechanisms to support uncompensated care and clinical education: disproportionate-share hospital payments and direct and indirect graduate medical education payments. This paper provides a history of how these traditional supports have evolved. We note that the need to reduce federal and state spending threatens the level of these payments, while changes in the health care delivery system highlight a range of design and technical inadequacies in the current support mechanisms.

Throughout the twentieth century, the U.S. health care system has supported uncompensated care and graduate medical education (GME) through a complex patchwork of revenue generated by patient care. Hospitals, the sites where most uncompensated care and physician training occur, have traditionally charged privately insured patients more than the cost of their hospital care. More recently, the federal government, through the Medicare and Medicaid programs, has created and maintained a set of structural support mechanisms based on patient care payments to help finance uncompensated care and health professions clinical education, particularly GME. Now the health care system is transforming from one based on a delicate web of confusing cross-subsidies to a system based on price competition in which both private and public purchasers want to pay only for the cost of the services their enrollees receive. Pressure to curb the rate of growth in state and federal health care spending threatens to erode the existing public support mechanisms for uncompensated care and GME.

The question in the current competitive environment is whether, how, and to what extent society will continue to support the additional roles of hospitals that now are funded with patient care revenue. Although other types of health care providers render uncompensated care and participate in health professions education, most of the public structural support mechanisms have been designed specifically as institutional- or hospital-level payments. This paper examines the history and current structure of hospital support for financing uncompensated care, GME, and its related activities. Although the competitive environment does not yet jeopardize the hospital community overall, certain types of hospitals, which form a safety net of care for the poor and/or provide GME and cutting-edge research, are at risk.1

A Historical Perspective

Care for the poor. The evolution of support for uncompensated care and GME closely parallels the development of the hospital. Hospitals in the United States, first built primarily for the poor, were organized as charities under the sponsorship of religious or-
ganizations and wealthy patrons. By the late nineteenth century, hospitals’ orientation had changed from charitable institutions to businesses as they began attracting patients from all socioeconomic classes. Today, public, private, and proprietary hospitals all, to varying degrees, serve their communities and provide care to persons who cannot pay.

- Clinical education and medical technology centers. Some hospitals also invest resources in a variety of other medical products. As scientific knowledge exploded in the twentieth century, some hospitals developed close affiliations with medical schools, becoming centers of advanced medical technology and providing the settings for clinical education with organized teams of attending physicians, residents, and students. In these institutions, commonly known as “teaching hospitals,” education and research are conducted simultaneously with clinical hospital practice.

- Financing: private and public. As hospitals evolved from charitable institutions to complex business enterprises, their reliance on patient care revenue increased. In 1922 patient care revenue accounted for 65.2 percent on average of the total revenue of general hospitals. In 1994, after the growth of private insurance and introduction of Medicare and Medicaid, 94 percent of hospital revenue on average was derived from services to patients.

Payments from private payers indirectly assist hospitals in meeting the costs of uncompensated care and GME-related activity. To large and varying degrees, hospitals “cost shift,” or obtain revenues in excess of costs from one payer of service to offset shortfalls in other categories.

Hospitals also rely on a set of publicly funded structural support mechanisms (Exhibit 1). Some federally appropriated funds, accessible under Titles VII and VIII of the Public Health Service Act, support a variety of clinical education programs. Other appropriated funds are available to hospitals to support certain at-risk populations, such as patients with acquired immunodeficiency syndrome (AIDS), migrant workers, and the homeless, but the bulk of public support is embedded in the Medicare and Medicaid programs. Medicare makes special payments to hospitals, called disproportionate-share hospital (DSH) payments, direct graduate medical education (DGME) payments, and indirect medical education (IME) payments, to maintain access to care for its beneficiaries and to support GME and its related costs. The Medicaid program, financed through a federal/state partnership, also makes DSH payments to hospitals to ensure access to care and, in many states, supports GME and its related costs.

These public support mechanisms are in jeopardy for two rea-
First, federal and state governments are seeking large targets to help them meet increasing budgetary constraints, and these special payments are substantial. Second, the structural support payments are based on fee-for-service payment systems and inpatient use of hospital services. Managed care uses different payment methods, reduces hospital use, and moves care to lower-cost and ambulatory settings. This dynamic distorts and weakens the methodologies for calculating these hospital payments.

### EXHIBIT 1
**Public Structural Supports For The Health Care Safety Net**

<table>
<thead>
<tr>
<th>Type of support</th>
<th>FY 1996 amount (billions of dollars)*</th>
<th>Purpose</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct graduate medical education payments(b)</td>
<td>$2.4</td>
<td>Direct costs of graduate medical education</td>
<td>Number of full-time-equivalent residents</td>
</tr>
<tr>
<td>Indirect medical education payments</td>
<td>4.3</td>
<td>Differences in patient care costs/access</td>
<td>Intern- and resident-to-bed ratio</td>
</tr>
<tr>
<td>Disproportionate-share hospital payments</td>
<td>4.3</td>
<td>Differences in patient care costs/access</td>
<td>Supplemental Security Income and Medicaid inpatient days</td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disproportionate-share hospital payments</td>
<td>19.0</td>
<td>Assistance to hospitals for services to low-income and Medicaid patients</td>
<td>Varies</td>
</tr>
<tr>
<td>Clinical education payments</td>
<td>1.0+</td>
<td>Direct costs of graduate medical education and/or indirect patient care costs related to teaching</td>
<td>Varies</td>
</tr>
<tr>
<td>Federally appropriated funds(c)</td>
<td>2.0</td>
<td>Varies</td>
<td>Appropriations/grants</td>
</tr>
</tbody>
</table>

**SOURCE:** Department of Health and Human Services.

**NOTE:** Medicare and Medicaid funding estimates are for fee-for-service spending and exclude amounts embedded in managed care rates where applicable.

- \(b\) Includes payments for nursing and allied health training programs.
- \(c\) Includes those programs in Titles VII and VIII of the Public Health Service Act, Ryan White funds, consolidated health centers, National Health Service Corps, rural health programs, and a few other programs.
Uncompensated Care

■ Amount. Hospitals and physicians traditionally have cared for patients regardless of their ability to pay. In this paper, uncompensated care is charity care and bad-debt expense. To a limited extent, all types of providers provide some uncompensated care, but data on total uncompensated care costs generally are available only from hospitals. Hospitals provided about $16.8 billion in uncompensated care in 1994, 19 percent of which was offset by government subsidies.4

■ Current financing. Hospitals finance uncompensated care through a variety of revenue sources. They may receive funds from federal, state, or local grant programs for specific services or special populations; philanthropies; gifts or their own charitable activities; and earnings from the fiscal year. Public municipal or state-owned hospitals receive state or local government appropriations, as do some private institutions. The federal government, through the Medicare and Medicaid programs, has implicitly supported uncompensated care by targeting additional funds toward certain types of hospitals that serve large numbers of poor persons. These payments include two separate and distinct DSH adjustments: one under the Medicare prospective payment system (PPS), and another under the Medicaid program. Some policymakers also believe that the current level of the Medicare IME adjustment is justified by the uncompensated care losses incurred by teaching hospitals.

■ Medicare DSH adjustment. In April 1986, with passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99–272), Congress mandated an explicit payment adjustment in the PPS for hospitals that serve large numbers of low-income patients. It required no new money. Funding was obtained by lowering the basic rate paid to hospitals and decreasing the level of the IME adjustment in recognition that teaching hospitals would receive a large proportion of DSH payments.

The original rationale for the DSH adjustment was to compensate hospitals for the higher operating costs they incurred in treating disproportionately large numbers of low-income patients. Several studies, conducted by the Health Care Financing Administration (HCFA) and the American Hospital Association (AHA), had demonstrated a relationship between higher Medicare costs and the percentage of a hospital’s patients covered by Medicare or Medicaid.5 A 1984 study by the Congressional Budget Office (CBO), based on 1981 data, showed that certain groups of hospitals, particularly those with relatively large shares of Medicaid patients, more than 100 beds, and large-city locations, would do worse, on average, under the new Medicare PPS than would other hospitals, because of
their higher costs. By 1990 another CBO analysis of more recent (1987) data showed that except for urban hospitals with more than 100 beds and the highest levels of service to the low-income poor, the higher cost differences associated with serving the poor had disappeared, and there was little justification for a DSH adjustment based on differences in costs.

However, the CBO noted another rationale for the DSH adjustment. Congress had become increasingly concerned that certain hospitals were at risk of closing as a result of treating large numbers of poor patients and began to view the DSH payment as a mechanism for mitigating hospitals' financial distress. Under this rationale, DSH payments were justified because they aided hospitals in maintaining access to care for low-income Medicare beneficiaries and other patients. Today, most policymakers acknowledge that the DSH adjustment is more a mechanism for channeling payments to hospitals that serve a high proportion of poor patients than it is a means of compensating hospitals for differences in operating costs.

**Mechanics of the DSH adjustment.** A qualifying hospital receives a DSH payment for each Medicare patient it treats under the PPS. The DSH payment is calculated as a percentage add-on to the basic diagnosis-related group (DRG) payment. Different DSH formulas are used, depending on where the hospital is located, how many beds it has, and its status as a rural referral center or sole community provider. The value of the hospital's DSH “index” determines the hospital's eligibility for a DSH payment and the size of the payment. The index, whose definition has not changed since the original legislation, is the sum of two ratios: the proportion of all Medicare days that are attributable to beneficiaries of Supplemental Security Income (SSI), a means-tested cash benefit program for aged and disabled people, and the proportion of all patient days for which Medicaid is the primary payer.

**Medicare DSH expenditures.** Since its enactment in 1986, the DSH payment has been modified in every budget reconciliation act except OBRA 1993 (P.L. 103-66). Originally intended to sunset, the adjustment was made a permanent part of the PPS in 1990. Each bill added more money to the adjustment but not always to every category of hospital. Legislation passed in 1990 (P.L. 101-508) added the most money to the adjustment, almost $1 billion, through formula modifications. Medicare DSH spending has increased almost fourfold, from about $1 billion in 1989 to more than $4 billion in 1996, and has grown faster than overall inpatient hospital payments. The CBO estimates that Medicare DSH payments will total $4.5 billion in fiscal year (FY) 1997, increasing to $4.8 billion in FY 1998.

As DSH spending has increased, so has the number of hospitals
receiving DSH payments. In FY 1991, the Prospective Payment Assessment Commission (ProPAC), which monitors the PPS for Congress, estimated that 1,558 hospitals, or 28 percent of all PPS hospitals, received DSH payments. By FY 1996, ProPAC found that 1,957 hospitals, or 38 percent of all PPS hospitals, were receiving DSH payments.

Although almost 2,000 hospitals receive this adjustment, Medicare DSH payments are highly concentrated. Ninety-three percent of total DSH payments go to large hospitals in urban areas, and teaching hospitals receive about 65 percent of all DSH payments. Finally, because Medicaid eligibility and coverage vary widely across states, Medicare DSH payments are distributed unevenly across geographic areas: The Middle Atlantic, South Atlantic, and Pacific regions account for 60 percent of all DSH payments but only 46 percent of Medicare discharges.

**Medicaid DSH payments.** The Medicaid DSH payment is based on the assumption that certain hospitals, in addition to providing care to Medicaid enrollees, also serve indigent persons who are not eligible for Medicaid and maintain many public health and social services for all area residents. Legislators recognized that these hospitals could not shift the cost of uncompensated care to the relatively few privately insured patients they serve. Congress took action so that access to care could be maintained. OBRA 1981 (P.L. 97-35) required states to “take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs” when setting inpatient hospital payment rates.

At first, states were slow to establish DSH payment adjustments, but in the late 1980s the federal government stimulated the creation of state DSH programs through legislation and regulation. In 1987 budget reconciliation legislation (P.L. 100-203), Congress established minimum criteria for designating and paying DSH hospitals and required states to designate every hospital that met those criteria as a DSH hospital. States could be more generous in their designation criteria or in their payment levels. This led to great variation across states and even among hospital types within states, as many states went beyond the minimum criteria.

In the late 1980s and early 1990s, Medicaid DSH payments exploded. States became very creative in increasing their Medicaid funding via provider-specific taxes, intergovernmental transfers, and donations from hospitals as part of the state share of Medicaid spending. These strategies increased federal payments to states with little impact on state general revenue funds. For example, providers, usually hospitals, would pay a tax or donate funds to the state. The state would then use these funds to make Medicaid pay-
ments and receive a matching payment from the federal government. The federal government objected to this because it believed that the mechanisms increased the federal contribution inappropriately.

In December 1991 Congress passed legislation, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), as a compromise between the federal government and the states. It restricted the types of provider taxes that states could use and banned the use of provider donations. The law also placed caps on DSH payments, limiting them to 12 percent of program expenditures at both the national and state levels. States whose DSH payments were more than 12 percent of state spending, so-called high-DSH states, were frozen at 1993 levels until the rest of their Medicaid expenditures grew so that DSH payments were 12 percent or less of Medicaid spending. States where DSH spending was below 12 percent were allowed to grow at the same rate as the rest of the Medicaid program. In 1993 Congress, responding to information that some hospitals were receiving excess DSH funds and that some states were diverting federal matching funds for purposes other than health care, placed further restrictions on particularly large Medicaid DSH payments to certain hospitals.

- **Current rules for Medicaid DSH payments.** The 1991 and 1993 legislative provisions for Medicaid DSH payments remain in effect. Federal matching payments for state Medicaid spending that is financed with revenues from provider taxes continue to be capped, and the 12 percent limit is still applied. States use a variety of methods to make DSH payments, but all are tied in some way to service for Medicaid enrollees and low-income persons.

- **Medicaid DSH expenditures.** Between 1988 and 1992 Medicaid expenditures grew on average 22.4 percent annually, while DSH spending grew a whopping 149.9 percent annually, from $400 million in 1988 to $17.5 billion in 1992. Legislative changes to the DSH program in 1991 and 1993 moderated the growth of DSH payments and overall program spending. Between 1992 and 1995 Medicaid DSH spending grew only 2.7 percent per year, increasing to $19 billion by 1995, considerably slower than the overall growth of the Medicaid program, which had dropped by then to 9.5 percent per year. As a result, whereas in 1992 DSH payments were 14.6 percent of all Medicaid spending, in 1995 DSH payments had dropped to about 12 percent of total Medicaid spending.

- **Other federal government support.** The federal government provides support for special populations through certain programs in the Health Resources and Services Administration (HRSA). Without the availability of federal funds for programs such as the Ryan White AIDS program, migrant health centers, and health care
for the homeless, hospitals would have to fund such activities with other revenues obtained through cross-subsidization. These federally appropriated funds, about $2 billion in FY 1996, are available to the health care system through grants and appropriations.17

**Nonfederal government support.** Another important source of support for uncompensated care is state and local government appropriations. State, county, or city tax dollars may be the primary source of funds for certain types of hospitals, such as public general hospitals. Data on appropriations are difficult to collect at the national level, but among members of the Council of Teaching Hospitals and Health Systems (COTH), twenty-three public municipal teaching hospitals reported receiving $1.7 billion in state, county, and city support for indigent care and general operations in FY 1995.18 Another thirty-eight state-owned public teaching hospitals received $700 million from state and county appropriations for indigent care, general operations, and medical education purposes.

**Clinical Education**

Medical education in the twentieth century has been intertwined with care for the poor, particularly in public hospitals where medical education programs have provided a workforce for care of indigent patients. Until the 1960s residents gained their primary clinical experience in public hospitals and on the charity wards of voluntary hospitals. In the mid-1960s and 1970s enactment of the Medicare and Medicaid programs sharply reduced the number of indigent patients, and GME changed, expanding training to other clinical settings. However, since the clinical component of medical education involves students and residents in the direct diagnosis and treatment of patients, and the poor have represented a substantial portion of patients cared for in educational settings, many view support for GME as support for uncompensated care in underserved communities.

**The cost of clinical education.** Teaching hospitals, which sponsor GME programs, incur significant direct and indirect costs in operating physician training programs. The direct costs consist of stipends and fringe benefits for residents, salaries and fringe benefits for supervising faculty, costs directly associated with supporting the GME program (such as the clerical personnel working exclusively in the GME administrative office), and allocated institutional overhead costs (such as maintenance, cafeteria, and depreciation).

Indirect costs are those incurred in providing an appropriate environment for clinical education. They include the higher patient care costs that accompany an academic infrastructure because teaching institutions tend to treat a much higher proportion of severely ill patients who require intensive resources. Teaching hospi-
tals also maintain a broader scope of highly specialized services and stand-by capacity, often on an around-the-clock, regional basis. Higher patient care costs also may result when a teaching program is located, for example, in the central core of a large urban area—where labor, land, and operating costs may be higher than in the suburbs. Finally, indirect costs include the reduced productivity of the hospital staff because they are educating residents and the processing of additional diagnostic tests or ancillary services that residents may order during their clinical learning experience.

■ **Current support for clinical education.** Support for clinical education comes from many sources, but most of it comes from hospital patient service revenue, such as payments from individuals; third-party payers, such as commercial insurance companies; government-financed programs, such as Medicare and Medicaid; and state and local appropriations. Fees from faculty physician practices, foundation grants, grants from the National Institutes of Health, and other diverse nonhospital sources, in addition to the Departments of Veterans Affairs (VA) and Defense, also support GME. The VA is the largest single provider of physician training sites in the United States today and funds about 9 percent of all residency positions each year at about 130 VA medical centers.

Because the Medicare program makes two explicit payments to teaching hospitals for their direct and indirect costs, many persons mistakenly believe that Medicare is the only payer of GME-related costs. Other purchasers of health services also participate in GME financing. Medicaid makes payments through a variety of explicit and implicit mechanisms. Private insurance companies contribute implicitly to direct and indirect GME costs by paying higher prices than these companies would pay to nonteaching hospitals.

■ **Medicare DGME payments.** Medicare DGME payments compensate teaching hospitals for the costs that are directly related to the graduate training of physicians, dentists, and podiatrists. Medicare does not pay the costs of clinical undergraduate medical education, although it occurs in teaching hospitals, usually alongside and intertwined with residency training. In establishing Medicare in 1965, Congress recognized the need to support residency training programs to meet the nation’s need for fully trained health care professionals and acknowledged that educational activities heighten the quality of care in hospitals.

■ **Mechanics of the DGME payment.** From 1965 until 1985 Medicare paid its share of each hospital’s historical DGME costs. Reimbursement was open-ended: If a hospital increased its costs, Medicare paid its share of the costs incurred. However, COBRA 1985 dramatically changed the DGME payment methodology in
April 1986 by uncoupling the link between costs and payments. Today, Medicare pays a portion of a hospital-specific per resident amount, which is updated annually by an inflation factor. These total per resident amounts vary widely, and in the FY 1984 or FY 1985 period on which the per resident amounts are based, they ranged from $20,000 to more than $100,000. Medicare pays a percentage of the per resident amount based on its share of total inpatient days in each hospital. In recent years the per resident amount has been adjusted to pay a higher rate for primary care residents.

The COBRA legislation also limited the number of years for which Medicare would fully support its share of residency training, and in August 1993 Congress made additional changes. Today, after the period required for a resident’s initial board certification in a specialty, Medicare pays only 50 percent of its share of the per resident amount. The program imposes no limit on the number of residents it supports, either at an individual hospital or in the national aggregate, as long as the residents are enrolled in an approved training program. Hospitals may receive payments for residents who are graduates of U.S. medical, osteopathic, dental, and podiatric schools and for trainees who have graduated from foreign medical schools.

- **Medicare DGME expenditures.** According to CBO estimates, the Medicare DGME payment totaled about $2.4 billion in FY 1996. Included in this estimate are about $300–$350 million in payments to hospitals for a portion of the direct costs of hospital-based nursing and allied health professions education.

- **The Medicare IME adjustment.** The IME adjustment, part of the Medicare PPS, compensates teaching hospitals for their higher Medicare inpatient operating costs relative to nonteaching hospitals. The roots of the IME adjustment lie in the limits placed on routine hospital costs in the 1970s. Even though Medicare initially reimbursed all Medicare-allowable hospital costs, the federal government soon imposed limits on acceptable costs. Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) authorized the secretary of health, education, and welfare to set payment limits on routine inpatient hospital costs. The cost limits, intended to reduce the variation in hospital costs acceptable to Medicare and the method of setting them, evolved between 1974, when the regulations were first published, and 1979. As the cost limits became more stringent, federal policymakers and the teaching hospital community expressed concern that teaching hospitals were being disproportionately harmed because the limits did not initially recognize the costs associated with operating an educational program. Eventually, teaching hospitals were permitted to remove their DGME costs before determining whether their costs were below the limits.
The concept of indirect costs was recognized in 1980.\textsuperscript{22} Government researchers, in studying the relationship between hospital costs and teaching status, found that even after removing DGME costs, teaching hospitals more often reached or exceeded their cost limits than nonteaching hospitals did. Researchers noted that a hospital’s intern- and resident-to-bed (IRB) ratio was related to an increase in hospital costs. As a result, the Medicare routine-cost limits for teaching hospitals were increased to incorporate a differential based on the IRB ratio in each hospital. In 1982 the adjustment for teaching hospital costs was included in the extension of the routine-cost limits to cover total hospital operating costs.

In December 1982, when the secretary of health and human services proposed a new Medicare payment system for hospitals, the resident-to-bed adjustment to the routine-cost limits was converted to a PPS payment, the IME adjustment, to adjust for the higher costs of teaching hospitals.\textsuperscript{23} The secretary’s estimate indicated that Medicare operating costs per case increased approximately 5.79 percent with each 10 percent increase in the number of residents per bed. However, two months after the secretary’s report, the CBO presented an impact analysis showing that the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment were set at the 5.79 percent level. The administration then suggested that the estimate be doubled to 11.59 percent for each 10 percent increase in the IRB. Congress supported this modification, and the IME adjustment was incorporated into the prospective payment legislation.\textsuperscript{24}

As more information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available. However, the 8.7 percent adjustment factor was reduced by 0.6 percentage point to finance part of the DSH adjustment, resulting in an IME adjustment factor of 8.1 percent during the time that the DSH adjustment would be in effect. The 8.1 percent IME adjustment recognized that teaching hospitals would receive a large share of DSH payments. The current 7.7 percent IME adjustment, enacted in OBRA 1987 (P.L. 100-203), took effect 1 October 1988.

**Mechanics of the IME adjustment.** For every Medicare case paid under the PPS, a teaching hospital receives an additional payment. A teaching hospital’s IME payment is determined by inserting its IRB into a formula that is written in statute. In FY 1996 a hospital with five residents for every 100 beds (IRB = 0.05) received a 3.77 percent add-on payment for each PPS case. A hospital with fifty residents for every 100 beds (IRB = 0.50) received a 33.73 percent add-on to its basic DRG payment.
Medicare IME expenditures. In FY 1996, 1,061 teaching hospitals received $4.3 billion in IME payments. IME payments were expected to account for about 6.2 percent of all PPS operating payments and 3.7 percent of total Medicare payments to hospitals. Although about 1,000 teaching hospitals receive IME payments, both residents and IME payments are concentrated in a few teaching hospitals. About two-thirds of all residents train in approximately 250 teaching hospitals. As a result, in FY 1996 this group of 250 hospitals, about one-quarter of all teaching hospitals, received $2.8 billion in IME payments, or about two-thirds of all IME funds.

Medicaid GME payments. Medicaid makes payments to hospitals in many, but not all, states for at least some GME-related costs. Aggregate data on whether and how state Medicaid programs pay for clinical education costs are sparse. An October 1995 study found that most states recognize both direct and indirect costs in their Medicaid fee-for-service payment systems. Of forty-two state Medicaid agency respondents, thirty-eight recognized costs for DGME, and thirty-one incorporated an IME adjustment in their payment systems. Estimated fee-for-service spending for both GME-related payments was about $1 billion in FY 1995. In contrast, the CBO estimated total FY 1995 Medicaid expenditures at $158 billion.

State support for GME. Teaching hospitals in some states receive public funds earmarked for GME. State appropriations are made most often to state-owned teaching hospitals. For example, teaching hospitals in the University of California system receive state funds for “clinical teaching support.” Among the 195 COTH hospitals reporting 1995 data, twenty-three hospitals received about $144 million in state funds for medical education.

Current Trends And Potential Threats
Both private and public structural supports for uncompensated care and clinical education are balanced precariously in the current environment. In this competitive market purchasers want to pay only for the services they believe are necessary and reasonable for the care of their insureds. The shift from indemnity insurance to managed care and the consequent ability to channel patients to certain settings have given purchasers market leverage and the ability to negotiate the most favorable price they can, narrowing hospitals’ ability to shift costs. Hospitals have responded to these pressures by reducing the rate of growth in their costs to below the rate of growth in their revenues, resulting in hospital margins that have remained stable or have even increased in some cases, but such dramatic cost reductions may be unsustainable in the future.
Government spending. Federal and state proposals to slow the growth in Medicare and Medicaid spending pose direct threats to current public financing mechanisms. The federal government is under increasing pressure to reduce the rate of spending growth, particularly in the Medicare Part A Hospital Insurance Trust Fund, now predicted to become insolvent in 2001. Congress and the administration have long viewed Medicare DSH and IME payments as ripe targets for savings. For example, in the Balanced Budget Act of 1995, Congress planned “across-the-board” reductions in Medicare DSH payments, starting with a 5 percent reduction in FY 1996 and increasing to a 30 percent reduction in 2000 and subsequent years. Proposals to reduce IME payments have persisted because the adjustment level continues to be higher than is empirically justified, and major teaching hospitals’ PPS inpatient margins remain high. Policymakers have criticized the open-ended nature of IME and DGME payments because hospitals may increase both payments by adding residents. Some also have questioned whether current public support is necessary in light of the excess supply of physicians and the type of training programs needed for the future. Policymakers have taken some steps to influence the specialty mix of the physician workforce and to save program funds through modest changes in DGME payments. They also have proposed limits on the total number of residents that Medicare should support.

In the case of Medicaid, health care reform efforts of the 1990s have called for significantly reducing or even eliminating DSH payments and redirecting them to expand health coverage to the uninsured. States are applying for Medicaid demonstration waivers and are proposing to reduce the level of DSH funds and use them to pay for eligibility expansion. Their rationale is to fund individuals, not institutions. They reason that with more people insured, there will be less need for extra funding for uncompensated care.

Finally, proposals to tighten federal discretionary spending even further may indirectly affect support for uncompensated care and clinical education–related activities supported through Titles VII and VIII of the Public Health Service Act. Budget reconciliation legislation passed in 1990 placed a cap on certain categories of discretionary spending. For FY 1994–1998, all discretionary spending for defense, international, and domestic purposes is under a single cap, making funding levels for these programs particularly stringent.

Managed care and other options. The shift of Medicare and Medicaid enrollees to managed care distorts the integrity of the current fee-for-service support mechanisms. Other types of arrangements, such as medical savings accounts (MSAs), present the same problem. When Medicare beneficiaries join managed care risk...
plans, the program pays 95 percent of an “up-front” monthly per capita (capitation) amount (the adjusted average per capita cost [AAPCC]) directly to the health plan. The plan’s capitation payment includes what Medicare traditionally spends on DSH, DGME, and IME payments under the fee-for-service payment system.

The managed care plan then contracts with hospitals and physicians to provide services. However, instead of using Medicare fee-for-service payment methods, the risk plan negotiates with providers, including hospitals. The rates that the plan negotiates with the hospital do not necessarily include the DSH, DGME, or IME payments that would be made to the hospital if the beneficiary remained in the fee-for-service system. Alternatively, the risk plan may direct patients away from the teaching or DSH hospital to a lower-cost site of care because the plan receives the same capitation rate regardless of the provider with whom it has a contract. In either case, under a risk contract, the teaching/DSH hospital would not receive the DSH, DGME, or IME payment. These earmarked funds may be used by the risk plan for purposes other than those intended by Congress. Some policymakers and advocacy groups have proposed separating the payments from the calculation of the managed care rates and paying them directly to a teaching or DSH hospital when the facility serves a Medicare risk-plan patient.

Medicaid managed care programs pose the same problem. In general, states set managed care rates using fee-for-service historical claims data. Unless removed before calculating the health maintenance organization (HMO) rate, hospital payments for DSH and GME-related costs are included in the capitated rates the state pays to managed care plans, which are not required to distribute the funds to hospitals. A few states (New York and Michigan, for example) have created mechanisms for “carving out” the GME-related dollars from managed care rates.

Problems with current support mechanisms. The transformation of the health care delivery system highlights a range of design and technical inadequacies with the current government-funded support structures for uncompensated care and GME. These mechanisms base the level of funding on measures of Medicare or Medicaid inpatient hospital use. As states move Medicaid recipients into managed care plans, the identification of these persons for purposes of calculating both types of DSH payments under fee-for-service becomes more difficult. Because these payments use inpatient days or discharges to distribute funds, managed care’s emphasis on reducing inpatient utilization eventually will result in diminished public support for uncompensated care and GME. Finally, these payments are targeted only to hospitals when the delivery system is shifting to
“Managed care’s emphasis on reducing inpatient utilization eventually will result in diminished support for uncompensated care and GME.”

ambulatory sites of care and nonhospital providers.

To some degree, all support mechanisms use proxies rather than direct measures. Medicaid activity represents service to the poor. The number of residents in the IME’s resident-to-bed ratio serves as a surrogate for differences in inpatient operating costs. Because they use proxies, the payments may not be targeted to the appropriate institutions. In addition, the purpose of the payments may be commingled, such as IME payments ensuring access to medical care.

■ Evolution of the competitive market. The transition to a competitive health care market has additional implications for municipal hospitals that traditionally have served the poor. As the market constrains prices for all hospitals, Medicaid rates become more attractive to other hospitals. Public hospitals that have relied on Medicaid patients as sources of revenue must now compete with private hospitals for these same patients. Municipal hospitals may be unable to compete because they offer fewer amenities or have more unattractive facilities or locations than their competitors have. Under Medicaid managed care, former patients may seek or be directed to other providers, leaving municipal hospitals with an even less desirable patient mix. In response to the fragile situation of these hospitals, local governments are making decisions to sell tax-supported hospitals or further reduce their support.

Another sign of increased competition is the relatively recent proliferation of niche providers, such as ambulatory surgical centers or cancer management companies. Niche providers siphon off the more profitable lines of traditional hospital services, leaving to hospitals the responsibility of providing costly, often unprofitable, services to very sick populations.

The competitive market also exposes the need to identify the institutional costs related to clinical research and the provision of community services, both of which traditionally have been funded with patient care revenue. As with medical education, there are added patient care costs and lost efficiencies because of the kind of environment needed to conduct clinical research. Hospitals now finance some research through contributions to medical schools, which may support the conduct of unsponsored clinical research.

Finally, hospitals provide community services, ranging from poison control to Meals-on-Wheels programs. These services are now financed from patient care revenues, gifts, grants, and retained earn-
ings and may be the first types of programs that hospitals reduce or eliminate when confronted with financial difficulty.

**Conclusion**

In the changing medical care marketplace, if government is unwilling to support the uncompensated care, clinical education, research, and community service missions of hospitals, private payers will feel comfortable avoiding these costs. No one opposes hospitals’ providing these services, but few see a responsibility to pay a price differential to support them. In this environment government policies set a benchmark for appropriate behavior and provide critical revenues. Federal and state initiatives to control health care costs, balance budgets, or extend trust funds place payments for uncompensated care and clinical education at risk.

The missions of uncompensated care and GME will not be preserved simply by increasing hospital efficiency. New and modified structures to finance uncompensated care and clinical education must be developed to preserve these functions. Action today can preserve the critical strengths of the U.S. health care system for tomorrow. Support structures for these missions are easy to destroy but costly and devilishly difficult to rebuild.

The views expressed in this paper are those of the authors and do not necessarily represent those of their respective associations. The authors acknowledge Richard M. Knapp and several reviewers for their constructive comments. A portion of this paper was presented at the Robert Wood Johnson/Health Affairs/Alpha Center conference, “What Is Happening to the Safety Net?,” 9 January 1997, in Washington, D.C.

**NOTES**

8. The inpatient days attributable to Medicaid managed care enrollees may be counted for Medicare DSH payment purposes. For a more complete discussion, see “Interpretation of Medicaid Days in Medicare DSH Adjustment Cal-
13. Ibid., 63–64.
16. Ibid., 2, Table 1.
17. Derived from the FY 1998 federal budget overview, which reports actual 1996 spending.
26. Ibid., 62.
30. ProPAC reported at its January 1997 meeting that in 1995–1996, major teaching hospitals’ aggregate PPS inpatient margin was 18.6 percent, compared with 3.7 percent for nonteaching hospitals. Major teaching hospitals continue to have the lowest total margins of any hospital group, however, at 3.7 percent, compared with 6.5 percent for nonteaching hospitals in 1995-1996.