

to hospitals that are the only source of care in a community, without also expanding coverage to the uninsured or otherwise subsidizing their care, will adversely affect their financial viability. This, in turn, could threaten access for enrollees in public programs.

- Some facilities benefit from the payment provisions for sole community or disproportionate share hospitals even though they do not serve these special functions. It is possible, therefore, to target payment reductions to protect access for Medicare enrollees served by hospitals that are truly isolated or that have the largest shares of low-income patients.

Alert 6: Funding for Graduate Medical Education Programs

Medicare payments for the costs associated with graduate medical education programs have become a particularly important source of revenue for teaching hospitals in the absence of explicit financial support for these activities from other payers. This is especially true because increasing competition in the private sector is making it harder for teaching facilities to obtain the higher payment rates needed to cover the added costs of their graduate medical education programs. Nevertheless, the Commission believes it is possible to reduce Medicare's graduate medical education adjustment by about 40 percent over the next three years.

- Many Medicare beneficiaries rely on hospitals that maintain postgraduate education and training programs for physicians and nurses. These hospitals incur additional indirect patient care costs related to their teaching mission. They also have direct costs due to resident salaries and benefits, faculty supervision, and overhead. The added costs of maintaining teaching programs have been explicitly recognized by the Medicare program and implicitly recognized through higher payment rates by some private payers.
- As competition in the health care system intensifies, the additional costs borne by teaching hospitals will place them at a disadvantage relative to other facilities. The role, scale, function, and number of these institutions increasingly will

be challenged. In the absence of alternative methods for financing medical education, patient care revenues will continue to be the major source of support for these activities.

- Medicare's indirect and direct medical education payments are an important source of revenue for this group of hospitals. The level of the indirect medical education adjustment, however, exceeds the added costs of furnishing care to enrollees. The Commission has recommended reducing payments to reflect only the difference in patient care costs that is related to teaching intensity. Doing this over three years will achieve the ultimate objectives of the Medicare program, while allowing teaching hospitals to adjust to the changing health care environment. In addition, direct graduate medical education payments have risen with the growth in the number of residents. Further evaluation of these payment policies is necessary, including better understanding of the value of training an increasing number of residents and the wide variation in per resident costs across hospitals. Medicare should also examine the relationship between its payments to teaching physicians for services provided to beneficiaries and its payments to facilities for graduate medical education.
- Because of Medicare's teaching and disproportionate share payments, the PPS financial performance of major teaching hospitals is better than that of any hospital group. Partly because of the significant amount of uncompensated care that many furnish, however, their overall financial health ranks among the poorest. The magnitude, distribution, and timing of any change in Medicare payments to these hospitals should take this into account.
- Medicare's capitated payment under its managed care risk contracting program does not appropriately distribute payments for the costs of teaching programs or of caring for a disproportionate share of low-income patients. The capitated rate reflects the extra Medicare payments provided to teaching and disproportionate share hospitals in the fee-for-service sector, regardless of whether Medicare HMO enrollees receive care in those hospitals. The relationship between HMOs and the teaching