

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7 - I-02
(December 2002)

Subject: Hospital and Physician Payment for Uncompensated Care,
Teaching, and Research

Presented by: Cyril “Kim” Hetsko, MD, Chair

1 At the 2001 Interim Meeting, the House of Delegates adopted as amended Resolution 810, which
2 calls for the AMA to “study current methods by which hospitals and physicians are paid for
3 uncompensated care, teaching, and research, and then consider whether, and if so, how to promote
4 an appropriate funding mechanism.” The Board of Trustees assigned the requested study to the
5 Council on Medical Service. In a telephone conversation with staff, the author of original
6 Resolution 810 (I-01), George Ross Fisher, MD, suggested that the Council examine the degree to
7 which hospitals cross-subsidize their teaching and research efforts, as well as their provision of
8 charity and other patient care, and whether this cross-subsidization is appropriate.
9

10 This report, which is presented for the information of the House, describes the current methods by
11 which hospitals and physicians are paid for uncompensated care, teaching, and research, as well as
12 the relevant provisions of recently enacted federal legislation. The report also discusses the current
13 financial performance of teaching hospitals, other funding mechanisms, and relevant AMA
14 policies. For the purposes of this report, “charity care” is defined as care provided for free or for a
15 reduced fee due to the financial need of the patient, “bad debt” is defined as the value of services
16 for which payment was expected but not received, and “uncompensated care” is defined as the sum
17 of charity care and bad debt.
18

19 CURRENT METHODS BY WHICH HOSPITALS AND PHYSICIANS ARE PAID FOR 20 UNCOMPENSATED CARE, TEACHING, AND RESEARCH

21
22 A large portion of the revenues of academic health centers (AHCs)—medical schools with an
23 affiliated hospital that may or may not be owned by the university and one or more other health
24 professions schools—is derived from patient care services. Anderson et al. (1999) reported that
25 clinical services represent 90% of hospital revenues, 84% of faculty practice plan revenues, and
26 47% of medical school revenues. Specifically, 29% of the revenues of AHCs came from Medicare
27 in 1994-95. In 1997, Medicare payments for direct and indirect medical education totaled an
28 estimated \$6.8 billion. AHCs also receive Medicare payments for disproportionate share and,
29 assuming a more severe case-mix, higher diagnosis-related group (DRG) payments. Some of the
30 indirect medical education (IME) payments are for unmeasured severity of illness as well.
31

32 In 1994, AHCs received 22% of their revenues from Medicaid. During the 1980s and early 1990s,
33 most Medicaid programs explicitly paid for direct and indirect medical education. State Medicaid
34 payments for graduate medical education (GME) were estimated at \$2 billion in 1995, not
35 including another \$3 billion that states spent directly on medical education. In addition, many
36 states used federal disproportionate share hospital (DSH) funding to cover the higher costs of
37 indigent patients. AHCs that serve more indigent patients also benefited from these additional
38 Medicaid payments.

1 Federal law requires that Medicaid payment rates for inpatient hospital care take into account the
2 situation of hospitals that serve a disproportionate number of low-income patients with special
3 needs. The requirement is known as the Medicaid DSH payment adjustment. DSH payments take
4 the form of either lump-sum payments or higher reimbursement rates to hospitals. States have
5 expended considerable energy and creativity in developing arrangements that bring in ample
6 federal funds with few or no new state expenditures. However, as a result of recently enacted
7 federal legislation, DSH payments fell by 2% per year in 1998-2000, according to Bruen et al.
8 (2002). Since DSH programs in many states are a source of revenue, limitations on these payments
9 potentially reduce states' ability to finance other Medicaid services.

10
11 During the 1990s, Medicaid programs began enrolling more beneficiaries in managed care. This
12 reduced the payments for direct and indirect medical education from the Medicaid program, and
13 forced AHCs to negotiate directly with managed care plans for higher payments, resulting in the
14 "steering" of Medicaid patients away from AHCs, with potentially devastating financial
15 consequences for these institutions. A case study of TennCare, for example, documented that one
16 of the primary threats to AHCs in Tennessee was that managed care plans were less likely to admit
17 Medicaid patients to AHCs, thereby reducing revenues to teaching hospitals. Studies in other
18 states reached similar conclusions about the impact of Medicaid managed care on teaching
19 revenues.

20
21 In 1994, AHCs received 31% of their revenues from private insurers. Prior to 1990, most private
22 insurers used either cost- or charge-based reimbursement to pay hospitals. This suggests that
23 private insurers were paying all of the higher costs of AHCs, and the widespread concern over cost
24 shifting suggests that they may have paid even more than actual costs. AHCs are 80% more
25 expensive per discharge than are non-teaching, community, and urban hospitals with more than 100
26 beds. However, when case-mix, input price differences, and other factors are taken into account,
27 the difference is less. Expenditures per discharge are estimated to be 25% more in AHCs than in
28 comparable institutions because of their educational and research missions, as well as their
29 investment in patient care innovation.

30
31 With the advent of managed care and increasing levels of price competition, some are concerned
32 that private insurers are less willing to pay the costs associated with education and research.
33 According to an April 1997 MEDSTAT Group study, managed care plans are willing to pay 5-10%
34 more for the added benefits of AHCs, and only 3-5% more in the most competitive markets.
35 Another study using data on large employer plans places this "premium" at 12%. All of these
36 estimates are well below the 25% cost differential, which suggests that there may be a relative
37 shortfall from private payers. It also should be noted that some managed care plans have recently
38 used tiered co-payments to discourage patients from seeking treatment at teaching hospitals.

39
40 Liaison Committee on Medical Education (LCME) questionnaire data indicate that more than
41 \$4 billion, or 15.6% of the revenues of U.S. medical schools in 1993-94, was derived from research
42 grants and contracts—11.7% from the federal government, 0.3% from state and local government,
43 and 3.5% from non-governmental sources. In subsequent questionnaires, LCME did not track this
44 information to the same level of specificity. For example, more than \$13 billion, or 30.6% of the
45 revenues of U.S. medical schools in 1999-2000, was derived from grants and contracts—19.1%
46 from federal research grants and contracts and 11.5% from other grants and contracts. The
47 Association of American Medical Colleges (AAMC) explained that the LCME data largely reflect
48 the limited revenue tracking capabilities of most U.S. medical schools.

1 Increased competitive pressures on AHCs may result in reduced discretionary funds from patient
2 care revenues to support the performance of unsponsored research, including institutionally funded
3 and faculty-supported activities. Weissman et al. (1999) found that the amount of institutional
4 support as a proportion of total funding was more than twice as high in less competitive markets
5 (6.1%), compared with the most competitive markets (2.5%). The authors concluded that many
6 AHC faculty receive institutional support to conduct their research or fund the research themselves
7 and that market pressures may affect the level of institutional funding available to faculty.
8

9 While academic physicians' time may be apportioned among education, research, and patient care,
10 they traditionally have not received explicit payment directly tied to their teaching and research
11 responsibilities. The 1984 recommendations of the General Professional Education of the
12 Physician (GPEP) Committee urged that “deans and departmental chairmen should elevate the
13 status of the general professional education of medical students to assure faculty members that their
14 contributions to this endeavor will receive appropriate recognition.” To reinforce its concern for
15 the educational mission, the GPEP report also recommended that each medical school establish a
16 distinct budget for its educational program, although it is not clear that any schools did so in the
17 years immediately following. However, with mounting financial pressures in the 1990s—reduced
18 patient care payments, growing regulatory burdens, and cost-sharing research requirements—some
19 institutions have begun to adopt mission-based budgeting and management practices, in which
20 costs and revenue streams are identified for each mission area.
21

22 Patient care revenues have subsidized teaching and research, as well as time spent delivering
23 uncompensated care. However, the emerging literature has suggested that any cost savings brought
24 about by managed care may limit the ability of providers to subsidize their provision of
25 uncompensated care. Between 1988 and 1999, the percent of physicians in practices with a
26 managed care contract increased from 61% to 91%. Despite the financial pressures that managed
27 care may have imposed on their practices, physicians' commitment to charity care remained as
28 high at the end of this period as it was at the beginning. Specifically, Kane (2002) found that
29 nearly two-thirds, 64.6%, of physicians provided charity care in 1999. Physicians were more likely
30 to provide charity care in 1999 than in 1988. In that year, 62% of physicians provided charity care.
31

32 RELEVANT PROVISIONS OF RECENTLY ENACTED FEDERAL LEGISLATION

33
34
35 In August 1997, President Clinton signed the Balanced Budget Act of 1997 (BBA), which
36 contained numerous spending reductions and changes in the Medicare law. Medicare spending
37 reductions in the BBA were estimated to total approximately \$116 billion. The legislation included
38 changes related to: direct graduate medical education (DGME), IME, and DSH payments;
39 limitation on the number of residents and the rolling average full-time equivalent (FTE) count;
40 payments to hospitals of IME costs for Medicare+Choice enrollees; and special reimbursement
41 rules for primary care combined residency programs. The draconian spending cuts mandated by
42 the BBA had a devastating financial impact on many teaching hospitals, and necessitated the
43 enactment of two subsequent pieces of legislation to provide teaching hospitals with some relief.
44

45 In November 1999, President Clinton signed into law a comprehensive legislative package that
46 included the “Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999” (BBRA).
47 The BBRA provided a total of \$16 billion over five years in relief from the BBA to hospitals,
48 physicians, skilled nursing facilities, home health agencies, and Medicare+Choice plans. Hospitals
49 received \$7.3 billion of the total BBA relief spending. For teaching hospitals, the BBRA included
50 provisions for freezing the BBA's reductions in the IME and DSH payments, and reforming the
51 outpatient prospective payment system. Other changes included modification of the DGME
52 payment methodology and physician payments. In addition, the Clinton administration agreed to

1 make several administrative adjustments to hospital and physician payments not included in the
2 \$16 billion legislative package. Also included in the larger comprehensive legislative package was
3 \$40 million for GME payments for independent children's hospitals.
4

5 In December 2000, Congress passed a comprehensive legislative package that included the
6 "Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000" (BIPA).
7 President Clinton signed BIPA into law on December 21, 2000. BIPA increased Medicare outlays
8 by approximately \$36 billion over five years, providing relief from the BBA to hospitals,
9 physicians, skilled nursing facilities, home health agencies, and Medicare+Choice plans. Hospitals
10 received approximately \$12 billion of the total BBA relief spending. For teaching hospitals, BIPA
11 included provisions for freezing the BBA's reductions in the IME adjustment; increasing the
12 inflation update adjustment to Medicare reimbursements for inpatient services; and eliminating
13 DSH payment reductions. Other changes included: increasing the floor of the per-resident
14 amount, which is used to calculate DGME payments; creating a transition period to comply with
15 regulations in relation to provider-based designation for hospital outpatient departments; and
16 codifying regulations that restrict the flexibility of the Medicare upper payment limit policy used
17 by states to make Medicaid payments to hospitals and other providers.
18

19 It also should be noted that, beginning in 1998, the AMA, along with the research community,
20 successfully advocated for doubling the National Institutes of Health (NIH) budget over a five-year
21 period. Specifically, NIH funding has increased from approximately \$13 billion in 1999 to a
22 projected \$27 billion in 2003. Medical schools receive nearly half of NIH funding in the form of
23 federal research grants and contracts, and the recent, substantial increase in this funding has
24 resulted in more and larger federal research grants and contracts for medical schools.
25

26 CURRENT FINANCIAL PERFORMANCE OF TEACHING HOSPITALS

27

28 In March 2002, the Medicare Payment Advisory Commission (MedPAC) reported that the overall
29 Medicare margin was 13% for major teaching hospitals in 1999, 14.6% in 1998, and 19% in 1997.
30 (A margin is calculated as revenues minus costs divided by revenues. These margins are based on
31 Medicare-allowed costs. The overall Medicare margin includes the five largest Medicare services:
32 acute inpatient, outpatient, rehabilitation and psychiatric units, skilled nursing facility, and home
33 health agency. It also reflects Medicare payments for DGME and bad debts.) The overall
34 Medicare margin for other teaching hospitals was 5.1% in 1999, 6.5% in 1998, and 10.1% in 1997,
35 and the overall Medicare margin for non-teaching hospitals was -0.1% in 1999, 1.8% in 1998, and
36 6.7% in 1997. MedPAC estimated that the overall Medicare margin for major teaching hospitals in
37 2002 would be 10.8%, compared with 4% for other teaching hospitals and 0% for non-teaching
38 hospitals. Similarly, according to a September 2000 General Accounting Office (GAO) report, the
39 average hospital with a large teaching program reported losses from its managed care business, but
40 Medicare payments were well above its costs. The report also found that managed care plan
41 payments were more generous than Medicare payments to the average responding hospital with a
42 smaller teaching program, although Medicare payments still on average covered its costs.
43

44 In addition, MedPAC reported that the total margin for major teaching hospitals was 2.4% in 1999,
45 the lowest since 1990, and 4% for other teaching and non-teaching hospitals, the lowest in 10
46 years. According to MedPAC, 43% of major teaching hospitals had negative margins in 1999,
47 compared with 31.1% for other teaching hospitals, and 35.2% for non-teaching hospitals. The
48 Council on Teaching Hospitals (COTH) reported that COTH hospitals had \$24.9 million in
49 uncompensated care costs in 2000 and \$28.2 million in 2001. Kane et al. (2001) found that non-
50 federal, post-GME physicians provided a total of \$24.8 billion in uncompensated care in 1994 and
51 \$35.4 billion in 1999.

1 Blumenthal et al. (1996) conducted case studies of seven nationally prominent AHCs during 1994.
2 The AHCs in their sample reported that their charges for each inpatient admission (adjusted for
3 case-mix) were approximately 15-35% above the comparable charges in community hospitals with
4 which they are increasingly competing for patients. In addition, Kuttner (1999) reported that, by
5 1993, about 28% of clinical income was “upstreamed” to defray the costs of the educational and
6 research activities of the academic center. However, no specific data were found regarding the
7 degree to which patient care revenue cross-subsidizes each of these activities or the provision of
8 charity care, nor was data available regarding the degree to which the educational, research, and
9 social missions of teaching hospitals cross-subsidize one another.

10
11 Responding to a request by the Council to comment on Resolution 810 (I-01), the Council on
12 Medical Education (CME) explained that teaching, research, and charity care do not typically
13 represent positive cash flows, and therefore do not generally cross-subsidize one another. Instead,
14 teaching hospitals rely on patient care revenues, along with other funding sources such as IME and
15 DSH payments, as well as federal and industry research dollars, to subsidize their educational,
16 research, and social missions. However, CME noted that teaching, research, and charity care
17 activities may indirectly support one another by, for example, sharing equipment and intellectual
18 property. Responding to a similar request for comment on Resolution 810 (I-01), the Council on
19 Scientific Affairs (CSA) also emphasized the importance of clinical dollars in supporting research
20 activities.

21 22 OTHER FUNDING MECHANISMS

23
24 AHCs and large teaching hospitals are looking to state legislatures to ease the transition required by
25 reductions in Medicare financing of GME and an increasingly competitive health care market, and
26 states are starting to respond to the needs of their local teaching institutions through new and
27 innovative financing approaches. For example, at least 13 states have removed the GME
28 component of their Medicaid managed care capitation rates to provide more direct payments for
29 teaching programs and institutions. Minnesota uses new general-fund tax revenues and additional
30 appropriations from the state’s tobacco settlement to finance its new Medical Education and
31 Research Cost (MERC) Trust Fund. Blewett et al. (2000) explained that the distribution formula
32 for the fund was designed to reflect the average cost of training and the number of trainees and to
33 account for a uniform proportion of clinical training costs for each provider type (5.9% in 1998).

34
35 In August 1999, MedPAC recommended to Congress that Medicare financing of GME be
36 maintained, but through a simplified method. Specifically, MedPAC proposed merging currently
37 used dual accounts to pay teaching hospitals—one for DGME and one for IME costs. MedPAC’s
38 rationale was based, in part, on the difficulty that AHCs and teaching hospitals have in accounting
39 for and distinguishing between the two sources of GME funds.

40
41 Mallon et al. (2002) identified 41 medical schools or medical school departments that used metric
42 systems to quantify faculty activity and productivity in teaching, and analyzed the purposes and
43 progress of those systems. Among the reasons articulated for developing these systems, the most
44 common was to identify a “rational” method for distributing funds to departments. More generally,
45 institutions wanted to emphasize the importance of the school’s educational mission. The authors
46 concluded that because of the concern about the teaching mission at medical schools, the number
47 of institutions developing educational metric systems will likely increase in the coming years.

48
49 In recognition of the inadequacy and instability of current Medicare funding for medical education,
50 the AMA, along with other organizations such as the Council on Graduate Medical Education
51 (COGME), supports an all-payer system of financing GME. Specifically, the AMA advocates that
52 a Graduate Medical Education Trust Fund that receives contributions from all payers for health

1 care should support the direct costs of GME. A private/public sector advisory body would study
2 and develop mechanisms for the distribution of funding from the fund, and payments would be
3 made from the fund to entities that incur the costs of GME. More than 25 Board and CME reports
4 made the case for an all-payer system of financing GME, and the AMA has advocated for such a
5 system before numerous governmental bodies.

6
7 Since 1998, the Council on Medical Service has developed a series of reports that address AMA
8 efforts to reduce the number of the uninsured, and expand patients' choice of health insurance
9 plans. Specifically, Council on Medical Service Report 9 (A-98) stated the AMA's preference for
10 a system of individually purchased and owned health insurance over employer-sponsored coverage.
11 Council Report 9 (A-98) also articulated a proposal to achieve such individual coverage through
12 the provision of individual tax credits and by encouraging employers to provide their employees
13 with a defined contribution for the purchase of health insurance.

14
15 Council on Medical Service Report 4 (A-00) established principles by which tax credit proposals
16 should be assessed, and Council on Medical Service Report 5 (A-00) established policy that health
17 insurance tax credits should be advanceable so that recipients would not need to wait until year's
18 end to receive the credit and purchase coverage. Council on Medical Service Report 10 (A-02)
19 presented several recommendations for specific legislative, private sector, and communication
20 actions to proactively advocate expanding coverage through a system of refundable tax credits and
21 individually owned health insurance.

22
23 In the fall of 1998, the AMA, AAMC, and Wake Forest University School of Medicine launched
24 the National Clinical Research Summit project to identify the problems facing clinical research, as
25 well as potential solutions. The project resulted in a November 1999 report, "Clinical Research:
26 A National Call to Action," which outlined a set of goals and recommendations. In response to this
27 report, and requests from the AMA and other sponsoring organizations, the Institute of Medicine
28 (IOM) and the Commission on Life Sciences of the National Academies convened a Clinical
29 Research Roundtable in early 2000.

30
31 The Roundtable brings together individuals from the academic health community, federal agencies
32 sponsoring and regulating clinical research, private sector sponsors of clinical research,
33 foundations, public and private sector insurance programs, health plans and insurance companies,
34 corporate purchasers of health care, and representatives of patient interests to discuss the
35 challenges facing clinical research and the approaches that might be followed to create a more
36 supportive environment for the conduct of a broad agenda of high quality clinical research. Myron
37 Genel, MD, Past Chair and former CSA member, currently represents the AMA on the Roundtable.

38 39 RELEVANT AMA POLICIES

40
41 The AMA has established an extensive policy base—more than 45 policies—related to hospital and
42 physician payment for uncompensated care, teaching, and research. Most notably, Policy
43 295.898(2) (AMA Policy Database) states that the AMA, in collaboration with other partners, will
44 work with legislators at the state and federal levels to establish an all-payer pool of funds to support
45 the missions of AHCs. Policy H-305.936(2-3) states that the AMA will seek restoration of
46 Medicare funding to teaching hospitals to a level that would permit maintenance of their
47 educational, research, and charity care missions until such time as an all payer system for GME is
48 implemented, and will continue to advocate for the adequate and stable funding of medical
49 education and research with equivalent funding for children's hospitals.

50
51 Policy H-225.997(4), on physician-hospital relations, states that physicians who provide teaching
52 or other services in excess of those ordinarily expected of members of the attending staff are

1 entitled to reasonable compensation. Policy H-305.946(2) encourages medical schools to develop
2 systems to more closely link revenues and teaching expenditures so faculty can receive explicit
3 payment for assisting the medical school in fulfilling its educational mission. Policy H-305.946(3)
4 states that the AMA will work toward the development of a system similar to Current Procedural
5 Terminology (CPT) codes for education with funding from a stable source.

6
7 Policy H-460.986 states that clinical research should be adequately funded by both public and
8 private sources, and Policy H-460.930(3) states that it is an inherent obligation of managed care
9 organizations to invest in broad-based clinical research. Policy H-460.981(1) states that academic
10 institutions and industrial firms should establish explicit guidelines, policies, and goals for
11 cooperative research ventures that will best accommodate the interests and integrity of both
12 organizations.

13
14 Policy H-165.886(1-2) urges physicians to share in the provision of uncompensated care to the
15 uninsured indigent, and opposes any health plan-originated prohibition or discouragement of the
16 provision of any uncompensated care by the plan's employed or participating physicians. Policy
17 H-160.969 opposes a special income tax deduction for providing medical care to the indigent.
18 Policy H-165.865 outlines the principles for structuring a health insurance tax credit, and Policy
19 H-165.933 states that the AMA will monitor state and federal initiatives in the area of health
20 system modification to ensure that the academic missions of medical schools and their affiliated
21 teaching hospitals are preserved.

22 23 CONCLUSION

24
25 As previously noted, AHCs have recouped a portion of the costs of their educational, research, and
26 social missions by charging paying patients prices that are typically between 15-35% above the
27 average for community hospitals. In addition, academic centers have used about 28% of their
28 clinical income to defray the costs of their educational and research activities. However, no
29 specific data were found regarding the degree to which patient care revenue cross-subsidizes each
30 of these activities or the provision of charity care, and the dearth of such information can be at least
31 partially attributed to the limited revenue tracking capabilities at many teaching hospitals. The
32 Council believes that mission-based budgeting and management practices, including the metric
33 systems referenced in this report, show promise in providing greater insight into the extent to
34 which cross-subsidization at teaching hospitals occurs.

35
36 The Council also believes that AMA policies more than adequately address appropriate funding
37 mechanisms for paying hospitals and physicians for uncompensated care, teaching, and research.
38 Specifically, a system of refundable tax credits and individually owned health insurance, an all-
39 payer system of financing GME, and adequate funding for research would mitigate teaching
40 hospitals' current reliance on inherently unstable patient care revenues to support their critical
41 missions. To that end, the Council believes that the AMA should continue its efforts—many of
42 which were highlighted in this report—to promote AMA policies related to hospital and physician
43 payment for uncompensated care, teaching, and research.

44
45 Finally, to the degree that further AMA studies are needed regarding hospital and physician
46 payment for teaching and research, the Council on Medical Service would encourage the Councils
47 on Medical Education and Scientific Affairs, respectively, to pursue such studies.

References for this report are available from the AMA Division of Socioeconomic Policy
Development.