LEVELING THE PLAYING FIELD: A REPORT OF THE COMMONWEALTH FUND TASK FORCE ON ACADEMIC HEALTH CENTERS

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Over the last 50 years, the nation's academic health centers (AHCs)—defined here as the 125 institutions that include at least a medical school and its closely affiliated clinical facilities and faculty practice plans—have come to serve a unique set of functions in the nation's health care system and in their communities. The AHCs produce a variety of health-related goods and services that have social value, but tend to be undervalued and undersupplied in competitive markets. These goods and services include basic and clinical research, the training of health professionals, certain highly specialized clinical services, and continuous innovation in health care services. In the balance of this paper, we refer to these functions as the "social missions" of AHCs. (Though some AHCs, especially the publicly owned centers, also consider care for the indigent a vital social mission, not all AHCs are disproportionate providers of indigent care. Therefore, this paper does not deal specifically with the indigent care mission of AHCs.)

A number of commentators¹⁻³ have suggested that the evolution of the US health care system into a more market-competitive system could have dramatic consequences for the ability of AHCs to discharge their social missions. Providing these goods and services requires resources. Until recently, AHCs and other teaching institutions financed a significant proportion of these costs through

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patient care revenues. Under traditional reimbursement systems, AHCs were often paid more—up to 30% more—than other health care providers in their markets for similar services. Efforts by managed-care organizations (MCOs) to secure the most competitive prices could compromise the complex web of clinical and financial relationships that AHCs have relied on to support their social missions. In addition, significant reductions in payments by Medicare and Medicaid have been proposed and are being considered actively as of this writing. These changes in public financing could also reduce patient care revenues of AHCs and thus their capacity to continue their unique social roles.

In response to the importance and potential vulnerability of AHC missions, the Commonwealth Fund established the Task Force on Academic Health Centers. This paper discusses the task force's first formal report, *Leveling the Playing Field: Financing the Missions of Academic Health Centers*.⁴ Like the report, this paper reviews the following four topics: (1) the task force's findings concerning the current status and potential vulnerability of the missions of AHCs; (2) the rationale for public support of those mission-related activities in the future; (3) the principles that informed the task force's deliberations; and (4) the recommendations of the task force.

Before proceeding, several points are worth noting. To begin, as the first product of a four-year study, the results reported here may be modified in light of additional data collection, analysis, and deliberation. Second, we do not address a topic of central importance to the long-term survival of AHCs and their social missions: the internal reforms that are necessary to improve the efficiency and effectiveness with which they fulfill their unique functions. We fully recognize that business as usual is no longer an option for AHCs, any more than it is for most other health care organizations in the current environment. Major internal restructuring and increased public accountability are essential for preserving the ability of AHCs to discharge the vital missions with which they have been entrusted. The task force is monitoring internal reforms under way within AHCs, is studying them in depth, and will report on their potential benefits and risks in the future.

Third, we recognize that some observers, including some members of our task force, believe that any recommendations concerning public support of the social missions of AHCs should wait until environmental pressures have forced AHCs to accomplish some or all of the internal reforms referred to above. Otherwise, it is feared, AHCs will never develop the political will to make the wrenching and difficult changes that are required.

While respecting these views, we believe that, as far as the unique goods and services produced by AHCs are concerned, the salient principle should be: first,

do no harm. A strong theoretical argument suggests that markets will not protect the social missions of AHCs. Indeed, as noted below, empirical evidence is beginning to show that missions are already starting to erode under market pressures. The AHCs can and must improve the efficiency with which they conduct both their routine patient care functions and their unique social missions. However, current threats are sufficiently pressing that we should ensure that those missions are protected—through public policy if necessary—while AHCs re-create themselves as more efficient and streamlined institutions. Furthermore, appropriately designed public policies need not prevent—and may even encourage—desirable internal changes within AHCs.

THE CURRENT STATUS AND VULNERABILITY OF ACADEMIC HEALTH CENTERS' SOCIAL MISSIONS

A review of the current empirical evidence concerning AHCs and their social missions reveals the extent to which society depends on them to fulfill these functions, the additional patient care costs associated with those missions, and the resulting vulnerability of the social missions of AHCs to market pressures.

SOCIETAL RELIANCE ON ACADEMIC HEALTH CENTERS

About 42% of all the nation's health-related research and development takes place in AHCs and closely related university laboratories. Most of the rest of the country's health care research takes place in industry. Thus, AHCs conduct the overwhelming proportion of the publicly supported health-related research and development in the United States. In addition to the health benefits realized from this publicly supported research, recent work⁵⁻⁷ has demonstrated the considerable economic returns generated by the health research conducted in academic health centers. The societal rate of return on public investment in university research generally has been estimated at 27% annually.⁷ Studies have demonstrated also that local economies experience significant spin-offs from health-related research and development undertaken by AHCs.

The nation also relies on AHCs to train many of its future health professionals. The AHCs train virtually all undergraduate medical students, half of the graduate trainees (interns, residents, and fellows), and substantial numbers of other health professionals, including nurses, physician assistants, pharmacists, and others. A growing consensus holds that we may be oversupplied with physicians, and that the numbers of graduate medical trainees should be curtailed by about 20%.^{8,9} However, there seems no dispute that AHCs can and should play a significant role in the future training of health professionals, provided they undertake reforms and develop community partnerships required to prepare health professionals better for managed care and other challenges.¹⁰

Another special function fulfilled by AHCs is the provision of disproportionate quantities of highly specialized health care services that require diverse and advanced technical skills and are sometimes delivered in such small quantities or to such poorly insured populations that they may be unprofitable. These services include complex trauma care, burn care, acquired immunodeficiency syndrome (AIDS) care, and intensive care for patients with multisystem failure. Though AHCs constitute only about 2% of all nonfederal community hospitals, they have 33% of the trauma units and 31% of the dedicated AIDS units.

A persuasive argument exists that society further relies on AHCs to combine these research, training, and patient care missions in ways that increase the effectiveness of all three. Research and development to improve patient care services, it is argued, are most effective when they are informed by the clinical needs of patients and the insights of health professionals caring for them.¹¹ This is especially true of clinical research, but may also apply to certain types of more fundamental investigations that address the causes and cures of disease.

The training of health professionals, some educators believe, is enhanced when they are schooled to some degree in the scientific method, which may improve their capacity for critical thinking and for lifelong learning. Exposure to the scientific method arguably occurs most naturally when clinicians in training can brush shoulders with active researchers. Finally, the delivery of highly specialized clinical services benefits from proximity to the clinical research that lays the basis for advances in such services.

Such interdependencies in the production of the social missions of AHCs suggest that these functions are, in the jargon of economists, “joint products.” Assuming this to be true, then if AHCs did not exist, other institutions with similar capacity to link these missions would have to be created to conduct them with maximum efficiency and effectiveness.

ADDITIONAL COSTS OF ACADEMIC HEALTH CENTERS’ MISSION-RELATED ACTIVITIES

Training and research create inefficiencies in the service delivery system that add expenses that cannot be easily segregated from the routine costs of care. The service-related missions of AHC hospitals—the provision of highly specialized services—also impose additional costs associated with treating more-complex and severely ill patients and providing technologically advanced care. Recent work by the Lewin Group suggests that in 1993 AHCs’ costs per case were \$2,681, or 28% higher than would be predicted based on case mix, wage differences, and other measurable factors alone.⁴ The comparable figure for other teaching hospitals was \$706, or 11%. Aggregate national estimates of the additional costs

of inpatient care at AHCs and other teaching hospitals in 1997 were \$18.1 billion, of which approximately \$8.1 billion were incurred at the 125 AHCs.

Other evidence suggests that these added costs of patient care at AHCs are at least partly attributable to and directly support mission-related activities. Based on a 1992–1993 survey of faculty practice plans, the Association of American Medical Colleges¹² estimated that such plans contribute about 28% of their clinical revenues to the academic missions of medical schools and AHC hospitals. Case studies of 15 AHCs conducted in support of the task force have also demonstrated that many AHC hospitals routinely transfer clinical revenues to affiliated medical schools.² Medical schools in particular have become extremely dependent on such clinical income. Between 1980–1981 and 1994–1995, the proportion of medical school revenues derived from clinical sources increased from 30% to 50%. Of the \$15 billion medical schools received from such clinical sources in 1994–1995, nearly \$10 billion came from faculty practice plans and another \$4 billion from hospital transfers.

A persistent question concerns how much of the unexplained, additional patient care costs of AHCs is attributable to inefficiency rather than to the conduct of mission-related activities. At present, data and analytic techniques necessary to answer this question definitively do not exist. For example, available risk adjusters are not powerful enough to ensure that differences in case mix and severity of illness between patients in AHCs and those in other institutions have been adequately accounted for in comparisons of the costs of care. Under the circumstances, it seems reasonable to conclude that the efficiency of care in AHCs can be greatly improved, but that even after such improvements are achieved, the problem of supporting the mission-related costs of AHCs will remain.

VULNERABILITY OF ACADEMIC HEALTH CENTERS AND THEIR MISSIONS TO HEALTH CARE TRENDS

Trends in both the private and public sector are likely to reduce the ability of AHCs to continue to subsidize their social missions through patient care sources. The reasons have to do with the competitive pressures on health care prices in private markets, the increased participation of public payers in managed care, and recently enacted cutbacks in public sector support for Medicare and Medicaid programs.

Private markets. Especially in highly competitive markets such as Los Angeles, San Francisco, and Minneapolis–St. Paul, Minnesota, pressure from purchasers to reduce premiums have made the higher prices of academic health centers increasingly unattractive to MCOs. This has required AHCs to reduce their fees substantially in the effort to narrow the differential between their prices and those of

competing institutions in their communities. Instead of price premiums of 20–30%, AHCs expect to command fees in competitive markets that are, at most, 5–10% higher than community-based competition.

To bring costs and prices down, AHCs are already making radical changes in the way they conduct business. Mergers are reducing the number of AHCs nationwide. In Boston, for instance, the number of teaching hospitals has dropped from 7 to 5 in the last two years, due to mergers of University Hospital and Boston City Hospital and the Beth Israel and Deaconess Hospitals. In St. Louis, Barnes and Jewish Hospitals have merged and consolidated, creating a single teaching facility with a common campus. The teaching hospitals of the University of California, San Francisco, and Stanford University are attempting to merge, as are Columbia Presbyterian Hospital (affiliated with Columbia University College of Physicians and Surgeons) and New York Hospital (affiliated with Cornell Medical College).

To meet the needs of MCOs, AHCs are transforming themselves into integrated health care delivery systems with the ability to provide a full range of health care services. The AHCs are building networks of primary care providers. For example, the Partners HealthCare System in Boston (formed from the affiliation of Massachusetts General Hospital, Brigham and Women's Hospital, and North Shore Medical Center) now has a network of more than 700 primary care physicians and contracts for over 200,000 capitated lives.

Despite such efforts, however, the ability of AHCs to compete effectively for private managed-care business is uncertain. Their competitors are also struggling to reduce costs and prices, starting from a lower base. Faced with the added costs of their social missions, AHCs are unlikely ever to lower their prices to the level of nonteaching facilities in their communities. In 1994, AHCs' market share for patients insured by health maintenance organizations (HMOs) was only 80% as large as their share of the privately insured market generally according to an analysis of discharge data for 24 metropolitan areas.¹³

Public policy. The loss of revenues associated with reduced prices and market share for private patients is compounded by changes in public policy. The AHCs are highly dependent on the Medicare and Medicaid programs. In 1994, Medicare and Medicaid patients together accounted for 47.6% of revenues in privately owned AHCs and 55.6% in publicly owned centers.

Two ongoing changes in Medicare and Medicaid are likely to have profound implications for the ability of AHCs to bear the added costs of their social missions. The first is the rapid enrollment of Medicare and Medicaid patients in MCOs. In 1996, 4.3 million (11%) of Medicare beneficiaries were enrolled in a

risk-contracting plan. Even with no change in current policies, the Congressional Budget Office projects this figure will grow to 23% by the year 2002 (January 1997 baseline estimates). The pace of enrollment is likely to increase since the enactment on 31 July 1997 of the Balanced Budget Act (BBA) of 1997, which allows physicians to form so-called provider service organizations that can enroll Medicare patients on an at-risk basis. The Medicaid program has experienced similarly dramatic growth in its managed-care enrollment, which now accounts for 40% of all beneficiaries.

Increased enrollment of Medicare and Medicaid patients in managed care leads to reduced AHC income, since MCOs seek the same savings in paying for publicly insured patients as they do for privately insured customers. Enrollment of Medicare patients in MCOs has also created another special problem for AHCs. Medicare has historically paid teaching hospitals an extra amount for each Medicare admission—called Graduate Medical Education (GME) payments—to cover Medicare's share of the patient-related costs of AHCs' social missions. The MCOs have not made such extra payments to AHC hospitals on behalf of their hospitalized Medicare patients, resulting in a loss of about \$700 million for AHCs and other teaching hospitals in 1997.⁴ As part of the BBA, Congress instructed the Health Care Financing Administration (HCFA) to extract GME payments from the per capita sums they give to managed-care plans that enroll Medicare beneficiaries and to pay those amounts to AHCs that admit Medicare patients covered by MCOs. However, since these provisions will be phased in over the next five years, it will be some time before GME losses associated with managed-care enrollment are fully restored to AHCs and other teaching hospitals.¹⁴

Another change in Medicare and Medicaid policy that threatens AHC social missions is recently enacted reductions in payments to providers. Of the \$116 billion in Medicare savings contained in the BBA, \$44 billion come from decreases in inpatient and outpatient fees to hospitals. Certain of these reductions will affect AHCs and other teaching hospitals more than nonteaching institutions. One component of GME funding, the so-called indirect medical education adjustment (IME), will be reduced over four years from 7.7% to 5.5%. The legislation also contains a 5% reduction in disproportionate share (DSH) payments over the next five years. These are especially important to inner-city and public AHCs, which serve large numbers of indigent patients.

The Prospective Payment Assessment Commission (PROPAC) has recently estimated that hospital margins from Medicare now approach 18%, suggesting that reductions in Medicare reimbursement are appropriate. However, overall

teaching hospital margins are only about 3.7%. High Medicare payments thus seem to be playing an essential, and perhaps disproportionate, role in ensuring the ability of AHCs to sustain their social missions.

This suggests that, when the federal government reduces Medicare payments to AHCs, as it did this year, it should consider the effect of these reductions on the mission-related activities of AHCs. Two developments suggest that federal authorities may be preparing to address the problems of AHCs more comprehensively. First, Donna Shalala, Secretary of Health and Human Services, has convened an internal task force; this group is reviewing the status of AHCs and the effects of changing federal policies on these institutions. Second, the BBA established a Medicare Payment Advisory Commission (MEDPAC), which will replace both PROPAC and the Physician Payment Review Commission. MEDPAC's congressional charter requests an extensive set of studies on the future of AHCs.

Evidence of change in mission-related activities. Despite these financial pressures on AHCs, evidence that their mission-related activities have been affected has been largely anecdotal to this point. However, several recent studies suggest that AHCs located in competitive health care markets may be experiencing reductions in such activities, at least compared with AHCs in other markets. Analyzing Medicare cost reports, Reuter and his colleagues found that AHCs in areas with high HMO enrollment were spending 22% less on graduate medical education in 1993 than were AHCs in areas with low HMO enrollment, and that the gap was widening because of slower rates of growth in teaching expenditures by AHCs in areas with high HMO enrollment.

Two recent studies indicate potential erosion of the research missions of AHCs in competitive markets as well. Moy and his colleagues¹⁵ found that, since 1990, National Institutes of Health (NIH) grant support has been growing less rapidly at AHCs in markets with high HMO enrollment than at institutions in markets with low or moderate HMO penetration. Reduced growth rates were more apparent in clinical than nonclinical departments, suggesting that reduced clinical cross subsidies in competitive markets may be reducing the ability of clinical researchers to compete for NIH grants with colleagues in markets that are less price-competitive.

The second study, by Campbell and colleagues,¹⁶ showed that clinical researchers located at AHCs in highly competitive markets (classified according to University Health System Consortium criteria) reported publishing 15% fewer articles in peer-reviewed journals than colleagues in less-competitive areas. Young re-

searchers were disproportionately affected. These findings raise concerns about whether young clinical researchers will be particularly affected by reductions in AHC revenues as price pressures mount in local markets.

PRINCIPLES GUIDING THE TASK FORCE'S RECOMMENDATIONS

These observations suggest a number of principles that should guide policy formulation concerning the social missions of AHCs.

- The social missions of academic health centers have intrinsic value for society, will not be financed optimally in a competitive marketplace, and deserve public support.

Nevertheless, public policy should not shield AHCs or other entities receiving public funds from the need to compete, when appropriate, with other health care providers on the basis of price and quality. Such protection would unduly favor training institutions. However, the role of AHCs in producing mission-related goods and services should not put them at a competitive disadvantage. This suggests a second principle.

- The goal of public policy should be to level the economic playing field for AHCs and other training institutions; that is, it should enable these facilities to fulfill their social missions, including graduate medical education, while competing with others on the basis of price and quality.

The creation of this level playing field will almost certainly require public financing of the mission-related activities of AHCs. Society is best served when those who gain from a particular good or service pay for it. In the case of the social missions of AHCs, society at large benefits. Bearing that in mind leads to the following principle:

- Methods of financing the social missions of AHCs should distribute the burden of payment broadly and equitably among those who benefit from them.

Recognizing that changes in government programs can have unintended consequences for the organizations and people affected, a fourth principle seems appropriate.

- Methods of financing the social missions of AHCs should introduce as few distortions as possible into health care markets. In particular, public policy

toward graduate medical education should not contribute to regional over-supply and specialty imbalance among the physician workforce.

RECOMMENDATIONS OF THE TASK FORCE

Informed by these principles, the task force made the recommendations delineated below concerning the future of the social missions of academic health centers.

CREATION OF A TRUST FUND

- A broadly financed pool, to be called the Academic Health Services Trust Fund, should be established to provide a stable and adequate source of dollars to pay for the higher costs of patient care associated with the social missions of AHCs and teaching hospitals. The amounts Medicare now pays for the direct and indirect costs of medical education should be transferred into the trust fund for distribution.

The proposed Academic Health Services Trust Fund would significantly reduce the need for AHCs and other teaching hospitals to cross subsidize their missions through patient care revenues. The AHCs would have to justify higher prices exclusively on the basis of a mix of sicker cases and better quality than their competitors, and the resulting competitive pressures would likely hasten efforts to improve internal efficiencies. With explicit control over support for mission-related activities, funding agencies would be in a position to set performance standards that would enhance accountability and efficiency in the conduct of AHCs' social missions. Managed-care organizations would be free to demand competitive prices from AHCs, secure in the knowledge that their mission-related activities were supported from other sources.

The idea of an Academic Health Services Trust Fund is neither unprecedented nor radical. Similar proposals have been contained in reports from the Prospective Payment Assessment Commission,¹⁷ a recent study by the Institute of Medicine,¹⁸ and in the 1995 budget reconciliation act, which was passed by the Congress, but vetoed by President Clinton. In the BBA, Congress chose not to revive this proposal, but it left the door open for reconsideration of the idea by asking MEDPAC to review the status of teaching hospitals and to make recommendations for supporting their research and educational functions in the future.

STRUCTURE AND FINANCING OF THE TRUST FUND

The creation of a pool to finance the social missions of AHCs raises related issues concerning the size of the pool, its financing, and the distribution of its funds.

- Public policy should support the nation's current capability to produce valued public goods and services in the areas of training health professionals, biomedical research, highly specialized health care services, and innovation in patient care. In the area of training, though, support should be commensurate with a decrease in new trainees to 110% of graduates from US medical schools and schools of osteopathy. The amount placed in the trust fund should be updated annually to reflect inflation and other changes in the direct and indirect costs of medical education and other social missions.

As noted above, there is no precise way at this time to measure the financial burden imposed on the delivery of routine patient care by AHCs' social missions. Taking into account the Lewin Group's analyses of the comparative costs of care in AHCs and other facilities and recent recommendations on the need to reduce the number of graduate medical trainees, the task force concluded that a pool of approximately \$15 billion would provide sufficient funds for AHCs to continue performing their missions at current levels. The \$15 billion figure reflects a 20% decrease in the number of first-year residents to 110% of the number of current graduates from US medical schools and schools of osteopathy.*

- The trust fund should be equitably financed through contributions from Medicare, Medicaid, and all private payers (including health insurers and

*The \$15 billion figure was calculated based on unpublished research by the Lewin Group. This work updates earlier analyses of hospital costs in 1993 performed for the Public Health Service and the Association of American Medical Colleges. The Lewin model employed data on nearly 5,000 hospitals from HCFA's Hospital Costs Report Information System (HCRIS), the American Hospital Association, and the Area Resource File. The direct costs of graduate medical education (DME) were based on expenses reported directly by the hospital. Researchers then used a regression approach to estimate the indirect costs of graduate medical education (IME) for all inpatient hospital services. Unlike the statistical models used by HCFA, the Lewin model explains the variations in the costs associated with all patients, not just Medicare patients, and includes both payment and market-related variables. To update the 1993 figures for the direct costs of GME to 1997, the Lewin Group used the percentage change in the CPI-U (Consumer Price Index, All Urban Consumers). The IME amount was updated to 1997 based on the percentage change in Medicare estimated hospital payments between 1993 and 1997. This estimate has certain limitations. First, it reflects only the direct costs borne by general acute-care hospitals and the indirect costs associated with inpatient care in these institutions. Second, expenses incurred at children's hospitals or in hospitals owned or operated by the Department of Veterans Affairs are not included. Third, the estimate assumes that the costs reflect efficient producers. If hospitals or training programs became more or less efficient, the estimate would change. Fourth, the estimate is based on 104,000 residents trained in 1993 and would change depending on the actual number of trainees. Finally, the estimate reflects the current allocation of training efforts between inpatient and outpatient settings. Increasingly, training is shifting from inpatient to less-efficient outpatient settings, in which the costs of GME are thought to be higher. However, no data are available to estimate the size of this effect.¹⁴

self-insured employed-based plans) or from the allocation of general revenues.

The missions of academic health centers are already supported by funds from four sources: Medicare contributions to the DME and IME (\$7.1 billion in 1997); Medicaid contributions to GME made on a state-by-state basis (\$1.4 billion); state and local government contributions to graduate medical education (\$220 million); and private sector payments (\$9.4 billion) in the form of higher expenditures for patient care at AHCs and other teaching institutions.

The task force recommends that these existing funding streams be redirected into the Academic Health Services Trust Fund for distribution to AHCs and other institutions that provide the social missions they have performed in the past. All the money required to support the trust fund is, from a conceptual standpoint, "already in the system." Indeed, the overall flow should actually be reduced somewhat to reflect the reduction in numbers of graduate medical trainees.

However, private sector contributions have not been earmarked for social missions in the past, and collecting them will require legislative action to channel these funds into the trust fund. Proposals to collect such funds must take into account public concerns with balancing the budget and the keen competition among health plans and providers. At least two options deserve consideration: an assessment, or tax, on private health plans for their fair share of the costs of AHCs' missions (a so-called all-payer tax) and the use of federal general revenues. Concern with the breadth and equity of any financing mechanism suggests an approach that relies at least partly on general revenues. However, other considerations—especially sensitivity to the federal budget deficit—argue for an approach that incorporates payments already allocated to the support of the social missions of AHCs. This would favor an all-payer tax to collect the indirect support already provided by private health plans.

- Medicare payments to the trust fund should include the Medicare GME funds now incorporated into payments to risk-contracting plans through the adjusted average per capita cost.

This recommendation was contained in the recently enacted BBA. If and when Congress creates the trust fund that the task force favors, it would be sensible to channel the GME funds carved out of payments to at-risk plans into the trust fund so that all payments for mission-related activities are coordinated and governed by uniform policies.

- Separate payments should be made for the direct and indirect costs that the social missions of AHCs and teaching hospitals impose on the costs of patient care. Payments for the direct costs of care should be made on a per-resident basis. Payments to hospitals for the indirect costs of medical education and other social missions should be linked to each treated case.

Ideally, the valuable social missions of AHCs should be financed directly. Realistically, however, it is difficult to disentangle the costs of carrying out these missions from the costs of providing patient care. Since the direct costs of medical education are more easily identifiable than the indirect costs, the trust fund should make payments for these expenses on a per-resident basis. However, payments should be based on a uniform national rate per resident, adjusted for local differences in wages, rather than on institution-specific historical costs as in the past.

For the indirect costs of the social missions of AHCs (including education, research, and highly specialized services), payments should reflect intensity of involvement in all mission-related activities. Ongoing studies are examining the contribution of each of the social missions of AHCs to patient care costs. Until these studies are completed and a better formula is developed, the trust fund revenues should be distributed using a formula identical to that which Medicare uses to determine its GME payments. When an improved formula is available, it should reward those institutions that further policy goals related to the number and mix of physicians, the conduct of research, and the provision of specialized and innovative services.

- Payments from the trust fund should be neutral with respect to the site of mission-related activities, so that these activities will occur in the most appropriate location. Demonstration projects should be conducted to test and evaluate new institutional arrangements, such as consortia, that may accelerate the transition of mission-related programs into ambulatory and community-based settings.

The existing system of Medicare payments for graduate medical education creates a bias toward inpatient training. Payments for mission-related activities should support training and other mission-related activities in a variety of settings and include institutions and sites with the skill levels necessary to provide diverse educational experiences, conduct needed research, and innovate in provision of all types of patient care.

At present, however, little is known about the marginal patient care costs of training and other mission-related activities in nonhospital settings. It is both

possible and desirable to begin supporting direct costs associated with training in ambulatory settings. Additional research is needed before payments for indirect costs of training and other mission-related activities can be made to nonhospital providers and settings.

- An independent commission, to be called the Academic Services Payment Review Commission, should be established to provide advice on the amount and distribution of trust fund dollars. The commission should monitor market changes and how the trust fund affects the social missions of AHCs. It should study direct and indirect costs associated with AHCs' social missions to ensure that trust fund support is being targeted and used appropriately. In addition, the commission should issue an annual report that presents its research findings and recommendations.

The health care delivery system continues to evolve at a rapid pace. To ensure that financial support is properly administered, the task force recommends the establishment of a new advisory commission—the Academic Services Payment Review Commission—that includes individuals with expertise in health care delivery and financing, medical education, health workforce policies, and clinical and basic research. The newly created MEDPAC does not, in the task force's view, have the necessary expertise to consider these issues in the future.

WORKFORCE ISSUES

- The level of trust fund support for the training mission of AHCs and other teaching hospitals should reflect the nation's requirements for physicians and physician scientists. Funds should be allocated preferentially to support the graduate medical education of US citizens.

The task force is opposed to open-ended public financing of physician training. Thus, in proposing the size of the trust fund, the task force lowered the level to reflect the emerging consensus on estimates of the future need for physicians. Still at issue, however, is the extent of public support for training and how the funds should be distributed to further national workforce goals.

Several approaches are conceivable. The task force favors setting a limit on total funding for graduate medical education and favoring US citizens in allocating this funding. Pending further study, the task force would rely on a modified version of the current Medicare payment formula. Money in the trust fund for supporting graduate medical education and other mission-related activities would equal the amount required to support the full costs of a number of trainees equal to 110% of residents and interns in AHCs and teaching hospitals who are US citizens. The calculation would be based on the current numbers and distribution of

trainees and volumes of patients at institutions. Further details are available from the task force.

- Safety net institutions that are primary sources of care in their communities and that depend on resident physicians to supply services should be given the resources necessary to continue this role.

In some cases, a hospital and its residents may be the only regular source of care for the poor and uninsured in their community. In the absence of definitive initiatives to cover the uninsured, federal policy should make certain that these institutions can perform their vital roles. This need not involve additional support for graduate medical education in these communities. One strategy would be to redirect existing funds to the National Health Service Corps for creating positions at these safety net hospitals.

- Adequate resources should be made available to AHCs and other safety net providers to care for indigent patients.

Although most AHCs provide care to indigent patients, the financing of such care should be separate from efforts to fund the other social missions addressed in this report.

SAVINGS TO MEDICARE

As we noted above, regardless of the overall merits of such payment reductions, the task force believes that they should not have been made without due consideration for their effects on the mission-related activities of AHCs.

- Any significant reductions in current Medicare support for the direct and indirect costs of graduate medical education and other AHC social missions should be accompanied by the establishment of the recommended financing pool with additional sources of funding.

At the current time, AHCs are more dependent than ever on clinical revenues from Medicare to sustain their social missions. Margins from Medicare patients are significantly higher than margins from other payers, which are likely to decline further as time goes by. Even if reductions in Medicare payments are justified, their effects on mission-related activities should not be ignored. This requires action to sustain the social missions of AHCs—in the task force's view, the creation of the proposed trust fund—in coordination with reimbursement cuts.

At a time of rapid, exciting, and unpredictable change in health care markets, it is easy to lose sight of familiar, time-tested truths. One such verity is that competitive markets will not adequately support the social missions that AHCs

have come to perform. At some point, therefore, governmental intervention will be required to preserve those social missions, or their supply, quality, or both will decline. Such governmental intervention need not and should not relieve organizations that are entrusted with conducting mission-related activities from the requirements to be accountable to the public and to undertake those missions with maximal efficiency. Public policy should strive for a reasonable compromise between protecting threatened social missions and allowing markets to function. We believe that the recommendations described above achieve that balance for the short term. Over the longer term, policy makers will have to reassess continually the effects of these proposed policies.

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