

COUNCIL ON GRADUATE MEDICAL EDUCATION

Resource Paper

The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education

A COGME Review

MARCH 2000

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Written by:

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

The views expressed in this document are solely those of the Council on Graduate Medical Education and do not necessarily represent the views of the Health Resources and Services Administration nor the U.S. Government.

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The Council on Graduate Medical Education

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. The legislation calls for COGME to advise and make recommendations to the Secretary of the Department of Health and Human Services (DHHS), the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Commerce. The Health Professions Education Partnerships Act of 1998 reauthorized the Council through September 30, 2002.

The legislation specifies 17 members for the Council. Appointed individuals are to include representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations, schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the Assistant Secretary for Health, DHHS; the Administrator of the Health Care Financing Administration, DHHS; and the Chief Medical Director of the Veterans Administration.

Charge to the Council

The charge to COGME is broader than the name would imply. Title VII of the Public Health Service Act, as amended, requires COGME to provide advice and recommendations to the Secretary and Congress on the following issues:

1. The supply and distribution of physicians in the United States.
2. Current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties.
3. Issues relating to international medical school graduates.
4. Appropriate federal policies with respect to the matters specified in items 1-3, including policies concerning changes in the financing of undergraduate and graduate medical education (GME) programs and changes in the types of medical education training in GME programs.
5. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathy, and accrediting bodies with respect to the matters specified in items 1-3, including efforts for changes in undergraduate and GME programs.
6. Deficiencies and needs for improvements in data bases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies.

In addition, the Council is to encourage entities providing graduate medical education to conduct activities to voluntarily achieve the recommendations of the Council specified in item 5.

COGME Reports

Since its establishment, COGME has submitted the following reports to the DHHS Secretary and Congress:

- First Report of the Council (1988)
- Second Report: The Financial Status of Teaching Hospitals and the Underrepresentation of Minorities in Medicine (1990)
- Scholar in Residence Report: Reform in Medical Education and Medical Education in the Ambulatory Setting (1991)
- Third Report: Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century (1992)
- Fourth Report: Recommendations to Improve Access to Health Care Through Physician Workforce Reform (1994)
- Fifth Report: Women and Medicine (1995)
- Sixth Report: Managed Health Care: Implications for the Physician Workforce and Medical Education (1995)
- Seventh Report: Physician Workforce Funding Recommendations for Department of Health and Human Services' Programs (1995)
- Report to Congress: Process by which International Graduates are Licensed to Practice in the United States (1995)

- Eighth Report: Patient Care Physician Supply and Requirements: Testing COGME Recommendations (1996)
- Ninth Report: Graduate Medical Education Consortia: Changing the Governance of Graduate Medical Education to Achieve Physician Workforce Objectives (1997)
- Tenth Report: Physician Distribution and Health Care Challenges in Rural and Inner-City Areas (1998)
- Eleventh Report: International Medical Graduates, The Physician Workforce and GME Payment Reform (1998)
- Twelfth Report: Minorities in Medicine (1998)
- Thirteenth Report: Physician Education for a Changing Health Care Environment (1998)
- Fourteenth Report: COGME Physician Workforce Policies: Recent Developments and Remaining Challenges in Meeting National Goals (1998)

COGME Resource Papers

- Preparing Learners for Practice in a Managed Care Environment (1997)
- International Medical Graduates: Immigration Law and Policy and the U.S. Physician Workforce (1998)

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The Effects of the Balanced Budget Act of 1997 on Graduate Medical Education

On August 5, 1997, President Clinton signed into law the Balanced Budget Act of 1997 (BBA), an omnibus legislative package primarily intended to balance the federal budget by 2002. This legislation contained major Medicare reforms, including a number of provisions that impact graduate medical education (GME). The BBA reforms encompassed some of the most sweeping changes in Medicare GME payment in the history of the program. Given the high level of Medicare support of GME training, approximately \$6.8 billion paid to teaching hospitals in 1997, these changes could have a major effect on the physician workforce, from supply and geographic distribution to the setting of training. It has been noted that this country has an imbalance in physician supply, specialty mix and geographic distribution.¹ The provisions of the BBA seemed likely to ameliorate these concerns by removing incentives for continued growth in the numbers of residents. It also provided incentives for training in out-of-hospital settings which would sustain primary care and rural training.

However, the BBA may have financially hurt some of the nation's teaching hospitals, considered by some to be the "crown jewels" of the American health care system. The BBA may have yielded other unintended consequences as well. This paper covers the GME provisions of the BBA and their effects on the training of the nation's residents. It discusses the concerns of financial burden expressed by some, and examines actual data to determine if these fears are objectively founded. Some of the effects on primary care and rural practice are examined. The paper then discusses a recent bill passed by Congress and signed into law to make corrections and refinements to the BBA. The GME provisions of the new legislation, the Balanced Budget Refinement Act of 1999 (BBRA), are intended to provide relief to teaching hospitals and physicians for what are perceived to be some of the BBA's unintended consequences.

MEDICARE SUPPORT OF GME

Teaching hospitals provide valuable services to both Medicare beneficiaries and non-beneficiaries. The GME training of physicians and other health

professionals in teaching hospitals is key to providing the nation with its supply of high-quality physicians, as well as enhancing the quality of care provided to hospital patients. Teaching hospitals are also in the forefront of medical research and technological innovations. They serve a disproportionately large number of patients who are poor, very sick and uninsured. Medicare payments to teaching hospitals were designed to create incentives for teaching hospitals to serve Medicare beneficiaries, as well as to support the training of physicians to meet beneficiaries' medical needs.

Medicare makes two types of payments to support training programs in teaching hospitals for physicians. The Direct Medical Education (DME) payment helps defray the direct costs of training physicians, such as salaries and fringe benefits of medical residents and faculty, and hospital overhead expenses. The Indirect Medical Education (IME) payment covers the additional operating costs that teaching hospitals incur in patient care, such as the costs associated with offering a broader range of services, using more intensive treatments, treating sicker patients, and using a costlier staff mix.

Despite numerous recommendations that the number of residency positions in the United States needs to be decreased, the number increased substantially between 1985 and 1996.^{2,3,4} A major cause may be the way Medicare reimbursed for GME. The DME and IME payments provided a strong incentive to hospitals to continue increasing their number of residents. Residents, for whom reimbursement is obtained from Medicare, provide services inexpensively and more flexibly than full-priced physicians and nurses. It was lucrative for hospitals to expand their residency slots. However, this changed when the BBA capped the number of residents qualifying for DME reimbursement at the number reported on or before December 31, 1996 and initiated a phased-in reduction of the IME adjustment factor. (The Act did allow for establishment of new rural-based residency training programs.)

Overall, the effectiveness of the BBA in restraining GME growth is difficult to assess because of confounding factors, insufficient data and difficulty in attributing cause to changes in numbers.

PROVISIONS OF THE BBA AFFECTING GME

Congress passed the BBA in 1997 partly in order to place some controls on the continuing growth of GME positions. The BBA contains several important changes in the GME funding mechanisms, designed to affect the number and mix of residents trained. The relevant provisions are:

1. A cap on total residents funded by Medicare. The number of residents for whom DME and IME can be claimed is limited to the full-time equivalent (FTE) count of residents enrolled in the hospital program in the hospital's most recent cost reporting period ending on or before December 31, 1996 and was made effective in the first cost reporting period beginning on or after October 1, 1997.
 2. A reduction in the IME Medicare adjustment factor from 7.7 percent per 0.1 intern/resident-to-bed (IRB) ratio in FY 1997 to 7.0 percent in FY 1998, 6.5 percent in FY 1999, 6.0 percent in FY 2000, and 5.5 percent in FY 2001 and subsequent years.
 3. A cap on the IRB ratio, which is used in calculating the Medicare IME payment. A hospital's IRB ratio is limited by the prior year's IRB ratio, which then acts as an IRB cap, making it essentially a one-year lagged cap.
 4. GME payments to non-hospital settings. Qualified non-hospital providers such as federally qualified health centers (FQHC), rural health clinics (RHC), and Medicare+Choice organizations, are permitted to receive DME payments for resident training that takes place in those settings if the non-hospital provider bears all or substantially all of the costs of training in the non-hospital setting (Table 1).
 5. Medicare IME payments to hospitals (as well as the DME payments they were previously able to get) for the time residents train at non-hospital ambulatory sites (such as health centers, HMOs, physician offices) if the hospital incurs all or substantially all the training costs at that site (Table 1).
 6. An ability for hospitals to affiliate for the purpose of establishing an aggregate full-time equivalent (FTE) cap. Hospitals under common ownership, or in the same or contiguous Metropolitan Statistical Areas (MSAs), or jointly listed as sponsors of a residency program, can affiliate to combine their FTE caps to create an "aggregate cap." Each hospital has its own FTE residency cap, but hospitals that do not fill their caps may affiliate with hospitals that want to exceed their caps, if all hospitals in the affiliated group agree. The total number of reimbursable residents for all the hospitals in the affiliated group may not exceed the aggregate cap.
 7. A three-year rolling average (two years for a hospital's first cost-reporting period beginning on or after October 1, 1997) for calculating the number of residents for DME and IME payments to hospitals to soften the impact of reductions in numbers of residents.
 8. Making available Medicare+Choice DME and IME funds that used to go to managed care organizations to teaching hospitals for Medicare+Choice patients. This "carve-out" increases in 20 percent increments from 20 percent for portions of the hospital cost reporting period beginning on or after January 1, 1998 to 100 percent in 2002.
 9. A voluntary resident reduction program where hospitals in the U.S. that voluntarily reduce residents by at least 20 percent over the five-year period, are eligible for transition funding. This could allow hospitals transitional funding to hire replacement staff or redesign services. (This program was modeled after the New York Medicare resident reduction demonstration.)
 10. A GME demonstration project involving several consortia. The Secretary of the Department of Health and Human Services (DHHS) will establish a demonstration project that will pay DME payments to a small number of consortia. On January 5, 2000, a solicitation for participation in the demonstration was published in the Federal Register.
 11. A DHHS study of the large variation in DME payment levels by facility. The Health Care Financing Administration (HCFA) is currently in the process of writing that report to Congress.
- The BBA cap on the number of residents is not applied to new programs established in rural underserved areas (non-MSAs according to interpretation by HCFA) until they have had three years to fill their resident cohorts, and to hospitals that have not had residency programs prior to January 1, 1995.
- The provisions that appear to have raised the most concern are the per-hospital cap on the number of residents and the reduction in the IME adjustment factor. The cap on the number of residents discourages facilities from adding or expanding residency programs. It is an across-the-board cap that limits the total numbers of residents, but in the

process, can hamper expansion of primary care specialties when hospitals do not make corresponding cuts in specialists. Although beneficial from the standpoint of curbing an oversupply of residents being trained and funded by Medicare, the limitation on primary care residents may conflict with the general goals of the Council on Graduate Medical Education (COGME) to promote the education and training of a mix of physicians consistent with current and future health care needs including in rural areas. Nevertheless, if the provisions lead to a slowdown in the growth rate of the physician workforce, while maintaining or increasing the number of primary care physicians, then the legislation is in line with COGME recommendations.²

The decreasing IME adjustment factor reduces IME payments to teaching hospitals. The IME adjustment factor is linked to the IRB ratio, which particularly affects academic health centers because they typically have the highest resident-to-bed ra-

tios. The resulting reduction in IME payments will be offset to some extent by the Medicare “carve-out” provision, which secures a major source of GME funding for teaching facilities, by removing the GME portion of payments to managed care organizations and providing them to teaching hospitals for treating Medicare managed care enrollees. IME payments amount to approximately two-thirds of the \$6.8 billion for GME paid annually by Medicare to teaching hospitals. In FY 1997 they totaled \$4.6 billion.⁵ The changes in the calculation of IME as a result of the BBA would have resulted in a 29 percent reduction in IME funding to hospitals at the end of the five-year phase-in period.^{6,*}

* The full reduction in the IME payment has been delayed by two years as a result of the recent passage of the Medicare Balanced Budget Refinement Act of 1999 (BBRA). For FY2000 and FY2001, the IME adjustment factor is set at higher levels than the original BBA provided for. The full decrease still takes place in FY2002. The BBRA is discussed further on page 10.

TABLE 1
Medicare Payments to Hospitals and/or Ambulatory Sites, Pre and Post BBA of 1997

Medicare Payment Recipient and Bearer of Costs	Training Site (rotations)	DME		IME	
		Pre-BBA	Post-BBA	Pre-BBA	Post-BBA
Hospital	Hospital inpatient or hospital-owned outpatient	Yes	Yes	Yes	Yes
	Non-hospital ambulatory entity (free standing)	Yes—payment to hospital when it pays resident salaries	Yes—payment to hospital when it bears all or substantially all training costs ¹	No—payment was not an option under federal statute	Yes—payment to hospital when it bears all or substantially all training costs ¹
Ambulatory: Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Medicare+Choice Entity	Non-hospital ambulatory entity (free standing)	No—payment was not an option under federal statute	Yes—payment to ambulatory site when it bears all or substantially all training costs ^{1,2}	No—payment was not an option under federal statute ³	No—no payment to ambulatory site, even when it bears all or substantially all training costs ^{1,3}

All hospital outpatient facilities affiliated with a hospital are paid by hospital inpatient rules. Free standing means not hospital owned or operated.

¹ “Substantially all” was redefined in the regulations implementing payments to non-hospital facilities to require payment for resident salaries and fringe benefits, faculty teaching costs and travel costs. Previously, it had been defined as only residents’ salary and fringe benefits.

² Payments based on reasonable cost determinations.

³ Although there are no provisions in the statute allowing IME payments to FQHCs and RHCs, those that engage in training may have higher operating costs which may be compensated as long as they do not exceed the operating payment caps determined by Medicare.

The voluntary resident reduction program can be a windfall to hospitals that already intended to reduce their training efforts. For them the incentive payments are bonus money. For hospitals that were simply considering trimming their programs, the voluntary reduction program can be the incentive that encourages them to do it.

The BBA provides for the establishment of a consortium demonstration project. This is in alignment with a previous COGME recommendation that the federal government fund twelve consortium demonstrations. In COGME's recommendation, the projects must be committed to providing a cost-effective administrative framework within which education and workforce reform can occur.⁷

CONCERNS WITH THE FINANCIAL EFFECTS OF THE BBA'S GME PROVISIONS

The reduction in the IME payments has led to anecdotal reports that teaching hospitals are experiencing diminishing revenues and profit margins, and in some cases losing money. The Association of American Medical Colleges (AAMC), American Hospital Association (AHA) and other groups have expressed concern over the IME provisions. Other organizations have joined them in espousing the BBA as harmful to the financial viability of teaching hospitals and their mission to provide graduate medical training, and service to the poor, uninsured, and very sick.

Predictions have been made that the BBA cuts could force some of the nation's leading teaching hospitals to reduce the scope of their services. Although these predictions may be valid, empirical data have not yet been sufficiently available to show whether teaching hospitals have suffered financially from the GME provisions of the BBA. Dr. Gail Wilensky of the Medicare Payment Advisory Commission (MedPAC) recently stated that systematic data since the BBA was enacted are very limited and she expressed doubt about the usefulness of reports issued by the hospital industry with projections showing an adverse financial impact from the BBA on providers. MedPAC found that the projections used in these analyses portrayed an inaccurate picture by assuming a rate of increase in costs substantially higher than what is known to have occurred.⁸

Further, there are no data on how private payers and the marketplace may have contributed to any financial problems. Traditionally the payments private third-parties made to hospitals on behalf of their insured patients exceeded Medicare and Med-

icaid payments in covering costs. Private insurers provided substantial support indirectly by paying hospitals for their activities that were substantially higher than the cost of producing patient care.⁹ Since the early 1990's however, private insurers have wrung substantial price concessions from hospitals by exploiting the system's excess capacity. Furthermore, it is frequently stated that private payers are increasingly unwilling to accept prices that reflect subsidies for GME. To maintain their market shares, some hospitals may have acceded to the demand for lower prices, sometimes below their costs.

Dr. Murray Ross, executive director of MedPAC stated "... we should not assume that the BBA is the entire problem. For several years, Medicare's payments rose faster than its costs, and the income this generated made it easier for hospitals to grant the discounts private payers demanded. Medicare payments are now rising more slowly than costs, and yet private insurers most likely have not lessened their demands. We believe that continuing pressure from the private sector has contributed substantially to the degree of financial distress hospitals are currently experiencing." Rep. Pete Stark (D-CA) echoed this sentiment in a written statement "If Medicare payments are not covering reasonable costs, then they should be adjusted. But if Medicare payments are adequate to pay for Medicare fee-for-service patients and are being used to cross-subsidize losses on managed care contracts, why should we ask taxpayers to make up the difference?"¹⁰

Residents and interns are a relatively inexpensive and versatile source of labor for teaching hospitals. Residents are often more cost-effective to use for providing patient care than practicing physicians and other health professionals. Residents generate revenue beyond their total salary and benefits. With the long hours of service provided by residents, the cost of GME programs might be viewed as a bargain.¹¹ It is understandable that hospitals that shift their hiring practices away from resident physicians as a result of the GME provisions of the BBA may incur additional costs.

The effects of capping residents paid by Medicare and the decreasing IME adjustment factor by themselves might not be detrimental to teaching hospitals' financial health. The GME provisions of the BBA together with other Medicare rules and changes in the marketplace may be behind some of the financial pressures on teaching hospitals. Hospitals are simultaneously affected by other factors that lower Medicare expenditures, such as greater compliance with Medicare payment rules and a longer time for processing claims.¹² At the same

time managed care is increasing and a price-based competitive system is emerging.¹³ These financial pressures may be inextricably linked, making it impossible to attribute blame solely to the GME provisions of the BBA.

It is difficult to find empirical, evidence-based information that supports concerns of either adverse effects or no effects from the GME provisions. However as time passes, more data are becoming available that should show credible post-BBA trends, and enable a clearer evaluation than currently possible with projected simulation models. A remaining problem that complicates a clear analysis is that national data can mask trends in local markets.

GME ACTIVITY TRENDS

Trend data on the numbers of residents, first-year residents and residency programs over the past six years show very little change, and no significant patterns. Even when there are small differences in numbers since 1997-98, they cannot be attributed to reduced GME funding as a result of the BBA, because other factors may confound that conclusion. Therefore the available data only enable a look at the trend, without establishing a definitive cause.

The total number of residents enrolled in ACGME-accredited and combined GME programs rose by a negligible amount each year from 1993-94 to 1997-98, and then, in the one year from 1997-98 to 1998-99, fell by nearly 800, making the 1998-99 number of total residents virtually equal to the 1993-94 number (Table 2). This pattern did not hold

with first-year residents. From 1997-98 to 1998-99 total first-year residents climbed slightly, from 24,516 to 24,571 while those with no prior GME dropped slightly, from 21,808 to 21,732. Between 1993-94 and 1998-99, total first-year residents dropped by 6 percent, while first-year residents with no prior GME was virtually unchanged.¹⁴ These numbers show no pattern that may be linked to the BBA.

While there was no increase in the number of total residents between 1993-94 and 1998-99, the number of U.S. medical school graduates (USMGs) comprised a decreased number and percent of total residency slots (Table 2).

But that was not the case for international medical graduates (IMGs). The total number of IMG residents, while fluctuating somewhat, increased by a striking 11.9 percent between 1993-94 and 1998-99, compared to USMG residents which decreased by 4.5 percent. The growth in the number of residents clearly has been fueled by IMGs. One of the recommendations COGME has supported is elimination of Medicare support for new exchange visitor IMGs. COGME believes that Medicare GME payments should be available only for residents expected to become part of the U.S. physician workforce.

There were no significant differences in the numbers and distributions of minorities entering U.S. GME programs during the past three years. The percent of black residents grew slightly, while the aggregate number of Hispanic residents remained stable.¹⁵

In spite of the relative stability of total resident numbers, the number of ACGME-accredited and combined residency programs grew since 1993-94 from 7,435 to 7,892 in 1998-99 (Table 2). The major increase in these programs was among subspecialties, which grew 10 percent in this period, from 3,230 to 3,561. Yet the number of residents in subspecialty programs actually fell by 2 percent during this time, from 12,012 to 11,752.¹⁶

The numbers of residents and programs show no clear pattern. Without additional data, it is impossible to evaluate the specific effects of the BBA on these numbers.

TABLE 2
ACGME-Accredited and Combined Specialty GME Programs and Residents

Year	Number of Programs	Number Total Residents ¹	U.S. Medical School Graduate Residents		International Medical Graduate Residents	
			Number	Percent	Number	Percent
1993-94	7,435	97,370	70,218	72.1	22,721	23.3
1994-95	7,509	97,832	67,524	69.0	23,499	24.0
1995-96	7,657	98,035	68,647	70.0	24,982	25.5
1996-97	7,787	98,076	66,893	68.2	24,703	25.2
1997-98	7,861	98,143	67,111	68.4	25,531	26.0
1998-99	7,892	97,383	67,085	68.9	25,415	26.1

¹ Includes DO, Canadian and Unknown residents.

EFFECTS ON TRAINING IN PRIMARY CARE SPECIALTIES AND FOR RURAL PRACTICE

This section discusses unintended consequences from the GME provisions of the BBA on the training of primary care residents and the training of physicians for practice in rural underserved areas. These residents are addressed because they are of prime interest to COGME, which supports expansion of primary care specialties and practice in rural areas. Additionally, some of the primary care specialties may have been especially affected by the resident caps due to their outpatient training characteristics and the increasing number of primary care residents.

FAMILY MEDICINE

COGME is particularly interested in family medicine because that specialty has been more successful than any other in meeting COGME's goal of training physicians who subsequently practice in rural areas. Family medicine is distinct in distributing physicians in urban and rural areas in proportion to the general U.S. population.¹⁷

Several characteristics of family medicine residency training make it especially vulnerable to the GME provisions of the BBA. It is the only specialty that historically has trained a large number of residents in ambulatory settings. At any one time, approximately one-third of its residents are receiving ambulatory training. Second, family medicine is a relatively new and growing specialty. Its expansion was continuing when the statutory cap on the number of residents was imposed as of December 31, 1996. Finally, two out of every five of its residency programs are the sole programs in hospitals, limiting hospitals' options to shift resources to this specialty.

Family practice is always training some of its residents at non-hospital affiliated ambulatory sites. Ten percent of the ambulatory settings to which family practice residency programs typically rotate approximately one-third of their residents are non-hospital affiliated. This translates to an estimated 250 to 350 family medicine residents (out of a total of approximately 10,000) who are training in free-standing settings.

A primary impact of the BBA cap on the number of residents in the hospital at the December 31, 1996 level is that some family practice residency programs did not have their full residency FTEs captured in the 1996 cost reports upon which the cap is based. That is because some residents who were on board at the time but training outside the hospital in non-hospital affiliated ambulatory sites

were not counted toward the cap since the cap covers residents *in the hospital* on the cutoff date.¹⁸ This results in an inability for the hospitals and programs to begin claiming Medicare reimbursements for those residents, under the cap.

In addition, the December 31, 1996 statutory resident cap applied to programs that had already been fully established for all three post graduate years (PGY) that may not have filled each post-graduate class in its entirety. These generally would be newer programs established prior to the statutory cap that did not have sufficient time to grow to fill each class to its full extent. Family medicine would be affected by this situation because it has been a growing specialty, increasing by a net of 11 or 12 programs annually in its climb from 380 programs in 1990 to 476 in 1998.¹⁹

Hospitals generally have the flexibility to rearrange residents between specialty programs. This gives hospitals the ability to augment or decrease certain specialty programs, based on their needs, provided they have the Accreditation Council for Graduate Medical Education (ACGME) slots available, and as long as the hospital does not exceed its FTE resident cap. Because 40 percent of family medicine training programs are the sole residency programs in hospitals, these hospitals cannot shift resident resources from other specialties.²⁰

Since passage of the BBA, family practice has experienced its first drop in the number of residency programs in almost a decade. From 1998 to 1999, the number of family medicine residency programs declined by two to 474, reversing a trend of growth since 1990. At the time the statutory cap was imposed, nine programs were in the pipeline for ACGME accreditation. At this time, it is not known exactly how many were unable to open. Some may have merged; some may have found a way to be re-sponsored by hospitals that never had residency training programs.

Family medicine produces more physicians who ultimately practice in rural areas than any other specialty. Nearly one in four of their graduates practices in rural, non-MSA counties. This compares to approximately 8 percent each for general internal medicine and pediatrics.²¹ One method family practice uses to train physicians is through separately accredited rural training tracks which provide two years of rural training to residents after an initial year in a non-rural sponsoring institution. Family medicine is the only specialty that uses a rural track mechanism.²² Twenty-nine of the 474 family medicine programs have these rural training tracks. Rural practice retention rates from these tracks are high, with 58 to 75 percent ultimately

practicing medicine in rural settings. At least eleven of these tracks have a one hundred percent retention rate of residents practicing in rural areas upon graduation.²³

The provision of the BBA that caps the number of residency slots has inhibited expansion of these tracks. Although a hospital can reallocate residents between residency programs, this can work to decrease ambulatory training as much as it can to increase it. And although the BBA allows the cap on residents to be adjusted for the establishment of new programs in rural underserved areas, family medicine cannot start new rural training tracks because these programs are hosted in non-rural hospitals which have not been allowed the adjustment to the cap that is granted for new rural-based programs. (See "Rural Practice" on page 9.)*

Data suggesting an impact from the BBA on family medicine training are available from the results of a survey conducted by the American Academy of Family Physicians (AAFP) and from data from the 1999 National Residency Matching Pro-

* The capping of resident slots in rural areas and the adjustment to the cap for rural-based programs as provided for by the BBA was modified in the BBRA, which allows for counting additional primary care residents, GME payments for non-rural facilities operating programs with rural training tracks, and certain urban hospitals being reclassified as rural facilities. The BBRA is discussed further on page 10.

gram (NRMP) match. The AAFP conducted a survey of the 474 family medicine residency programs in October, 1998. Of these, 282 programs responded, a 60 percent response rate. The data, not yet publicly released, are summarized in Table 3.²⁴

While these results have not yet been fully analyzed by AAFP, they suggest a possible plateau in the numbers of programs and residents, with the potential for an eventual decline. Although nearly the same number of programs were increasing their residents as decreasing them, 45 programs had been told by their sponsoring institutions to decrease their number of residents within the next three years.

The results also indicate a significant reduction in the number of new rural tracks that were still being planned after passage of the BBA. Prior to the BBA, 45 programs were planning a new rural training track; after the BBA, only 24 programs were continuing with this plan.

NRMP data also suggest a plateau in the number of family medicine residents being trained. The match results for 1999 show that for the first time in a decade, family medicine did not offer a growing number of family medicine resident positions. In addition, the number of second year positions which has usually grown each year by approximately 100 due to new residents entering from osteopathy and other sources, grew by only ten in 1999.

As of July 1, 1999, there were 10,632 family practice residents, approximately the same number as the year before. Absent a net shift of residents into family medicine from other specialty programs, the number of family medicine residents will probably stabilize at approximately 10,600.

INTERNAL MEDICINE

The specialty of internal medicine may be seeing an indication that a few residency programs are closing. In 1999, seven programs requested voluntary withdrawal from the residency review committee (RRC) accreditation process. This compares to nine voluntary withdrawals in 1998, five in 1997, three in 1996 and none in 1995.²⁵ The RRC does not track the reason that residency programs request voluntary withdrawal. In most cases they are assumed to have merged with training programs in other institutions, although it is known that at least one program in Cleveland closed effective December 31, 1999.^{26,27} Even with this information, and a slightly increasing trend in the numbers of internal medicine training programs requesting

TABLE 3
Responses to AAFP Survey of Family Practice Residency Programs' Expansion Plans

	<i>Number of Programs</i>	<i>Total Programs</i>
Family medicine programs responding to survey	282	474
PROGRAM NUMBERS		
Program is closing	5	282
Program is increasing the number of residents this year	25	282
Program is decreasing the number of residents this year	27	282
Program not decreasing the number of residents this year, but told they will have to within the next three years	45	282
RURAL TRACK NUMBERS		
Programs planning a new rural track prior to the BBA	45	282
Programs still planning a new rural track	24	45
Programs planning the same size new rural track	20	24

Source: Unpublished Data, AAFP, October, 1998

TABLE 4
Internal Medicine Resident Physicians
and Programs, 1995 - 1998

	1995	1996	1997	1998
Internal medicine residents	21,079	21,298	21,714	21,130
Internal medicine subspecialty residents	7,742	7,432	7,373	7,335
Internal medicine programs	416	417	415	410
Internal medicine subspecialty programs	1,499	1,496	1,443	1,397

Source: JAMA, Medical Education Issues, 1996 through 1999.

voluntary withdrawal, there are no causal data available to show that the closure was a result of the GME provisions of the BBA. Anecdotally the BBA is blamed for many of the financial problems being experienced by hospitals and internal medicine residency programs, as it is for other specialties.

It is possible that the trend in the numbers of internal medicine residents may reveal a slight pattern that could be linked to the BBA. The total number of internal medicine residents enrolled in ACGME-accredited and combined GME programs rose each year from 1995 to 1997, and then, in the one year from 1997 to 1998 fell by nearly 600, making the 1998 number of residents virtually equal to the 1995 number (Table 4). This trend mimics the pattern with total residents discussed in the section "GME Activity Trends".

Residents in internal medicine subspecialty programs declined steadily between 1995 and 1998, with the largest drop from 1995 to 1996. The number of internal medicine residency programs was virtually unchanged since 1995, and the number of subspecialty programs declined slightly each year. In all, there is very little evidence at this time to show that the numbers of internal medicine residents and programs are affected by the BBA.

PEDIATRICS

Since Medicare payments for GME training are a function of the percent of inpatient days attributable to Medicare patients, reimbursement for pediatric GME largely occurs in non-children's hospitals caring for both adult and pediatric patients. In pediatrics, the general sense among medical educators is that when money gets tight, pediatric programs in non-children's teaching hospitals suffer. Adult services are often more profitable to hospitals, so when a hospital needs to cut back on a program or residents, some believe that pediatrics is one of the first programs to be eliminated or reduced.

It is difficult to determine if a reduction in the production of pediatricians would be acceptable, given that there may be an oversupply of pediatricians.²⁸ Recent analyses of the physician workforce have yielded widely disparate estimates of how appropriately physician supply will match demand in the 21st century.²⁹ Because of the high output of training programs, the rate of growth in the pool of practicing pediatricians is outpacing the rate of growth in the population of children.³⁰ The number of pediatricians per 100,000 U.S. children is increasing and projected to increase further. The number of pediatric residents climbed from 7,354 in 1995 to 7,728 in 1998 (Table 5).

Yet pediatric physician shortages remain in rural areas, remote frontier areas and impoverished urban areas. Moreover, there does not seem to be an oversupply of pediatric subspecialists. In fact, there is concern that some subspecialties within pediatrics may be experiencing shortages. From 1995 to 1998, the number of residents in pediatric subspecialty programs fell from 1,536 to 1,482, a trend that is mirrored across all specialties. This occurred while the number of pediatric subspecialty programs has been steadily increasing and new subspecialty categories have been added.

As of December, 1998, 11,823 pediatric subspecialists had been certified by the American Board of Pediatrics in 14 subspecialties, which represents just under 18 percent of all board certified pediatricians.³¹ In recent years, there has been a decline in interest in pediatric subspecialization attributable to a number of changes in medicine: a shift to managed care; an increased emphasis on primary care by payers; an increasing debt burden among residents; an increasing subspecialty faculty dissatisfaction; and decreased research support.³²

With both the percent and absolute number of pediatric residents entering subspecialty training falling, jobs are currently available in many subspecialty areas.^{33,34} While a recent study of medical journal recruitment advertisements for general pediatricians shows a peak in 1990 followed by a decline, the number of positions advertised for pediatric subspecialists remained steady.³⁵

Some in the pediatric medical education community are concerned that the BBA cuts in GME may worsen the possibility of a subspecialist shortage. However, the number of pediatric

TABLE 5
Pediatric Resident Physicians and Programs, 1995 - 1998

	1995	1996	1997	1998
Pediatric residents	7,354	7,618	7,613	7,728
Pediatric subspecialty residents	1,536	1,530	1,490	1,482
Pediatric programs	215	216	216	209
Pediatric subspecialty programs	472	479	491	554

Source: JAMA, Medical Education Issues, 1996 through 1999.

subspecialists had already begun to decline two years prior to the passage of the BBA. There are no data which directly link the legislation to the trends in pediatric GME.

A particular problem in financing pediatric GME is the extremely low level of Medicare payment to "free-standing" children's hospitals. Although about one-third of all general pediatric residents and one-half of all pediatric subspecialists are trained in free-standing children's hospitals, low Medicare utilization in these children's hospitals keeps them from receiving adequate Medicare subsidies for GME. The BBA addressed the ongoing issue of financing GME in children's hospitals by requesting that the MedPAC and National Bipartisan Commission on the Future of Medicare review the issue. Legislation has subsequently been enacted to begin to provide federal support for GME in children's teaching hospitals.

The American Academy of Pediatrics believes it is important to support efforts to assure that an adequate but not excessive number of well-trained pediatricians enter the labor market in accordance with the needs and numbers of U.S. children. To that avail, the Academy supports the establishment of an independent, national health care workforce commission or policy body to project aggregate need for the health care workforce including pediatricians, to determine the necessary number of residency positions on a national basis, to allocate residency positions by specialty and subspecialty, to implement appropriate incentives to reinforce the selection of primary care, and to conduct ongoing research to ensure the availability of appropriate data on which to base workforce decisions.³⁶

RURAL PRACTICE

The number of physicians practicing in rural areas has been inadequate. COGME has documented that osteopathic physicians are proportionately more likely than allopathic physicians to be

located in rural areas. Among allopathic physicians, family practitioners are more likely to settle in rural areas than any other specialty.³⁷ Because family physicians comprise nearly half of the entire physician population in rural areas, the impact of the BBA provisions on family medicine is inextricably linked with the future supply of rural physicians. Limiting the number of residents in rural areas could be detrimental to the health care needs of rural populations since restricting the

number of residents training in an area ultimately limits the pool of physicians most likely to settle and practice in that area. Studies confirm that residents tend to settle close to their residency program and residents who train in rural settings are more likely to settle there than their urban-based counterparts.³⁸

There were some beneficial provisions in the BBA whereby GME could be used in a targeted way to particularly meet rural needs in overcoming physician shortages. The provisions allowed for 1) the cap on residents to be adjusted for the establishment of new programs in rural underserved areas; 2) DME payments to institutions other than hospitals, particularly federally qualified health centers (FQHC) and rural health centers (RHC) to encourage the placement of medical residents and interns in rural settings (See Table 1); and 3) IME payments to teaching hospitals for resident time spent outside the teaching hospital to encourage hospitals to place residents in ambulatory settings without a loss of revenue (See Table 1).

However, implementation has shown that not all of these provisions have turned out to enhance efforts to train physicians for practice in rural areas. The rural exception to the hospital-specific cap on residency slots in new programs applies only to hospitals physically located in rural areas. The cap remains in effect for urban teaching hospitals with new programs in rural training tracks or with rural satellite facilities. This provision particularly impacts family medicine, which cannot count residents in new rural training tracks toward the cap, since they originate in non-rural institutions. The exacting interpretation used by HCFA has resulted in virtually excluding any growth in rural training tracks and rural-based satellite facilities. In addition, existing rural programs are not allowed to expand.

The provision of IME payments to teaching hospitals for residents in non-hospital settings is of little use when established residency programs are

capped only at the number that had actually been *in the hospital*. Residents in the non-hospital sites still count against the hospital's overall cap if the hospital bears all or substantially all training costs, while the hospital functions without those resident services and cannot recruit other residents to fill the loss. Thus hospitals are not anxious to transfer residents to outpatient rural settings because of the overall cap limiting the total number of residents.

Finally, although DME payments can now be made to FQHCs and RHCs, IME payments cannot be made to either the non-hospital facility or to the hospital under that provision. At the same time, the DME component is usually too small to sustain a resident in most of these settings, because the proportion of Medicare patients upon which the DME calculation is based, is on average less than 10 percent. This provision leads to the need for stand-alone clinics to associate with a hospital in order for the hospital to capture the DME and IME.³⁹

Rural hospitals are particularly dependent on Medicare revenue—more so than their urban hospital counterparts.⁴⁰ Rural hospitals consider themselves particularly vulnerable to the effects of the BBA. Recent data to bear this out come from a WWAMI Rural Health Research Center study of six well-managed rural hospitals. Case studies of these hospitals showed sudden financial difficulty since 1997, with fewer being profitable, and more having negative operating margins.⁴¹

MORE DATA WITH TIME

Although the conclusion cannot be reached that the BBA has been responsible for financial pressures of teaching hospitals or for a decline in numbers of residents and residency programs, the BBA may have disproportionately affected some specialties such as family medicine, limited the training of physicians for practice in rural areas and compounded financial weakness for teaching hospitals. There is further concern that the BBA's impact would sharply escalate in intensity if additional cutbacks occurred.

As time passes, new information is developing using real data from post-BBA years. HCIA Inc. and Ernst and Young recently released a study where they recalculated the impact of the BBA on hospitals. Because they now have substantially more hospital data for 1998, they used actual 1998 figures to show true, non-projected effects of the BBA. One result is that hospital profit margins in 1998 were 4.2 percent, which is 2.7 percentage points lower than they originally predicted when the study was done using projected 1998 data.^{42,43} As addi-

tional years of data become available, HCIA Inc., Ernst and Young, and other analysts will continue to monitor and assess the effects of the BBA.

THE MEDICARE BALANCED BUDGET REFINEMENT ACT OF 1999

As a result of the current outpouring of concern over the effects of the BBA, changes to refine and “correct” the law were underway in Congress. A number of bills had been introduced in the Senate Finance Committee and the House Ways and Means Committee and Commerce Committee to change some of the GME provisions of the BBA. Legislation to refine the BBA was negotiated between the Senate, the House and the Administration, and ultimately incorporated into more comprehensive legislation, which was recently signed by the president and enacted into law. The legislation, HR 3426, entitled the Medicare Balanced Budget Refinement Act of 1999 (BBRA) addresses many BBA issues, including some of the GME provisions. The legislative package was signed into law as part of a broader omnibus bill, HR 3194 on November 29, 1999.

The BBRA provides a series of payment policy adjustments under Medicare that offer financial relief from the BBA to hospitals, physicians, and Medicare+Choice plans, as part of a larger legislative vehicle.

It is possible that policy makers will never respond to a comprehensive plan that restructures GME financing. Rather there may be significant incremental changes, similar to those in the BBA, followed by a period of adjustments, including legislative relief as has happened with the BBRA.⁴⁴

The BBRA included the following GME provisions:

1. Revised the multi-year reductions of IME payments, by freezing the IME adjustment factor at 6.5 percent in FY 2000 and 6.25 percent in FY 2001, and falling to the BBA's original 5.5 percent in FY 2002 and beyond.
2. Established a national average payment methodology in computing DME. The agreement creates a “corridor” surrounding a weighted standardized national average per-resident amount for DME, beginning in FY 2001. Hospitals with per-resident amounts below 70 percent of a geographically adjusted weighted national average will receive payments at the 70 percent level in FY 2001, and at a level updated annually by the consumer price index

(CPI) thereafter. Hospitals with per-resident amounts between 70 and 140 percent of the average will continue to receive their current payment levels, updated annually by the CPI. Hospitals with per-resident amounts above 140 percent of the average will have their payments frozen at current levels in FY 2001 and FY 2002, and updated in FY 2003 through FY 2005 by the CPI minus two.

3. Increased flexibility in providing GME in rural and other areas by permitting hospitals to increase the number of primary care residents that they count in the base year limit by up to three full-time equivalent residents if those individuals were on maternity, disability, or a similar approved leave of absence. Hospitals located in rural areas are permitted to increase their resident limits by 30 percent for DME and IME payments. In addition, non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, may receive DME and IME payments for cost reporting periods beginning on April 1, 2000 and for discharges occurring on or after April 1, 2000.
4. Permitted reclassification of certain urban hospitals as rural hospitals if the hospitals are located in a rural census tract of a metropolitan statistical area; or are located in an area designated by State law or regulation as a rural area or designated by the State as rural providers; or meet other criteria as the Secretary specifies.

These provisions are beneficial for teaching hospitals, primary care practice and rural facilities. The financial pressures on teaching hospitals are relieved with the higher IME adjustment factor for the next two years. The national average payment methodology for DME will help hospitals with lower than average per-resident amounts. Primary care resident caps may be increased by up to three full-time equivalents. Rural hospitals may increase their caps by thirty percent, while non-rural facilities operating in rural areas may begin to receive DME and IME payments, and certain hospitals can be reclassified as rural. These new provisions appear consistent with COGME's goals of increasing primary care training, and service in rural underserved areas.

One desired provision not included in the legislation was an adjustment on the number of residents reimbursed by Medicare to include residents training in ambulatory settings who were unintentionally excluded in determining hospital caps.

Nevertheless, the increase in primary care residents counted in the base year by up to three FTEs is a step toward remedying some of the unintended consequences from the BBA of 1997.

CONCLUSION

Without further data, the impact of the Balanced Budget Act of 1997 can be looked at in one of two ways. One is that it was important that the BBA be enacted after nearly three decades of relatively uncontrolled growth in Medicare spending. Medicare subsidies had allowed teaching hospitals to expand rapidly by subsidizing their expenses on a cost-plus basis, thereby facilitating the enrollment of too many residents, and hiring too much faculty, who in turn trained too many specialists. Now teaching hospitals must adapt to lower payments. The other view is that medical schools and their affiliated teaching hospitals are being made to absorb shocks for a system that fails to acknowledge their unique role in training physicians.⁴⁵ Thrown into the impact are specialties not in oversupply, whose growth might be curbed. From the data that have been analyzed, it cannot be determined that one side has more credence than another. It appears that both positions have some validity.

RECOMMENDATIONS

COGME should revisit this issue in 2002, when empirical data for three to four years since the BBA implementation will be available. At that time, hospital revenues and profit margins will be able to be evaluated, as well as the numbers and specialties of residents training and their deployment to rural areas. Furthermore, passage of the BBRA will result in changed numbers, which will need to be assessed in future evaluations. The underpinning of any future recommendations requires the acquisition of reliable data.

In the meantime, COGME should continue to monitor the effect of the BBA and the BBRA on GME in its effort to advise and make recommendations to improve the training of residents and the financing of graduate medical education. COGME should keep abreast of developments as a result of the legislation. These would include being aware of ensuing discussion on the adequacy of Medicare reimbursement as well as requests for relief. COGME should pay particular attention to provisions of the legislation that result in a shift in training from hospital based specialties to non-hospital settings, as well as the training of primary care physicians and those in rural settings.

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