HEALTH POLICY CORNER

# How Does Medicare Pay for Graduate Medical Education?

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Medicare was created in 1966 to pay for the care of the nation's senior citizens. Congress reluctantly and temporarily decided Medicare would pay teaching hospitals for physician training. As of now, "temporarily" has lasted 46 years.

Originally, Medicare paid for "allowable costs," which included the costs of graduate medical education (GME) programs. However, in 1983 when Congress enacted the Prospective Payment System (PPS), which pays a fixed amount per hospitalization for clinical care based on the patient's diagnosis-related group (DRG), it had to decide whether it would continue having Medicare pay for GME. It chose to continue paying, using a two-part funding mechanism for teaching hospitals. Direct GME (DGME) payments help hospitals pay the salaries of residents, teaching faculty, and support staff. DGME is the product of three numbers: a per resident amount that varies by hospital, adjusted annually for inflation; the number of residents in the hospital (capped for each hospital at 1997 levels); and the fraction of discharges from the hospital that are Medicare beneficiaries. The Indirect Medical Education (IME) payment is a percentage amount added on to each DRG payment. The percentage is calculated via a complex formula (the only US statute containing an exponent!), where the key factor is the ratio of interns/residents to beds (IRB ratio). Congress defines the change in IME percentage for each 10% change in a hospital's IRB ratio (IME adjustment).

Of the $9.2 billion Medicare paid for GME in 2010, $3 billion was for DGME and $6.2 billion for IME. The money is paid to hospitals sponsoring training programs rather than to the training programs or other hospitals where training occurs. While about 1,100 hospitals receive GME payments, 66% goes to the 200 hospitals that have the largest numbers of residents. These teaching hospitals receive between 15% and 43% IME add-on to their DRG payments.

When Congress created the IME payment, it deliberately set the IME adjustment at 11.6% (for each 10% change in the IRB ratio)—twice what economists believed it should be, so as not to risk damaging the financial stability of teaching hospitals. Since 1983, Congress has whittled the IME adjustment down to 5.5%. This means that a hospital with an IRB ratio of 0.6 gets IME payments 5.5% higher than one with a ratio of 0.5. The Medicare Payment Advisory Commission (MedPAC) has argued that this adjustment is still more than twice what is justified by comparing costs at teaching and non-teaching hospitals and should be decreased. This would mean reducing IME payments, harming hospitals that rely heavily on this funding stream.

GME funding is financed by the Medicare payroll tax. It is not vulnerable to the annual Congressional appropriations process. It can be changed only if Congress changes the laws authorizing Medicare.

While DGME payments clearly address the costs of training, IME payments are intended to address the increased severity of illness of patients cared for at teaching hospitals, compared to those cared for at non-teaching hospitals, as well as the inefficiency costs resulting from having trainees. This means that proposals to redirect the GME funding stream to training programs instead of hospitals (as many have proposed) would likely only apply to DGME money. IME money would continue to stay with hospitals.

Historically, training programs that have trainees in settings outside the hospital lose funding for the time trainees are there, which discourages community-based training. The Affordable Care Act allows hospitals to count training time spent outside the hospital in GME calculations, but more work is required to strengthen these provisions.

SGIM works with other organizations to support GME funding and improve how funding is allocated. We also advocate for non-Medicare GME funding including Title VII. Our next education policy article will cover that.

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