

HEALTH POLICY

HOW DOES MEDICARE PAY FOR GRADUATE MEDICAL EDUCATION?

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When the law creating Medicare was passed in 1965 to pay for the care of the nation's senior citizens, Congress reluctantly decided Medicare would temporarily pay teaching hospitals for physician training. Temporarily has lasted more than 52 years! Medicare originally paid hospitals for "allowable costs," including the costs of graduate medical education (GME) programs. When the Prospective Payment System (PPS) was created in 1982, paying hospitals a fixed amount per admission for clinical care depending on the patient's diagnosis-related group (DRG), Congress had to decide again whether Medicare would pay for GME. It chose to have Medicare continue paying, using a two-part funding mechanism. Direct GME (DGME) payments help teaching hospitals pay the salaries of residents, teaching faculty, and support staff along with other program costs. DGME is the product of three numbers: 1. a per resident amount, often determined in the 1980s, that varies by hospital, adjusted annually for inflation; 2. the number of residents in the hospital (capped for each hospital at 1997 levels); 3. the percentage of hospital inpatient days from Medicare beneficiaries. The Indirect Medical Education (IME) payment is a percentage amount added to each DRG payment. The percentage is calculated via a complex formula (the only U.S. 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 \$11.8 billion Medicare paid for GME in Fiscal Year 2016, \$3.5 billion was for DGME and \$8.3 billion for IME. The money is paid to hospitals sponsoring training programs rather than to the training programs, associated medical schools, or other hospitals where training occurs. While more than 1,100 hospitals receive GME payments about two-thirds of the money goes to the 200 hospitals with the largest numbers of residents. These teaching hospitals receive between 15% and 43% IME add-ons 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) and others have 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, so is not vulnerable to the annual Congressional appropriations process. It can be changed only if Congress changes the laws authorizing Medicare, which doesn't happen very often. All GME funds go to hospitals which can spend them as they see fit, not to medical schools or residency programs. While DGME payments clearly address the costs of training, IME payments are intended to address the increased costs for taking care of patients cared for at teaching hospitals who are sicker than those cared for at non-teaching hospitals, as well as the (alleged) inefficiency costs resulting from having trainees. This means that proposals to redirect GME funding to training programs instead of hospitals (as many have proposed) would likely only apply to DGME money. IME money would likely continue to go to hospitals.

Historically, training programs that have trainees spend time in settings outside the hospital or hospital-owned facilities lose funding for the time trainees are there, discouraging community-based training. There have been solutions advanced to ameliorate this, but they are part of the annual appropriations process.

The Trump administration proposed changes in the GME program earlier this year that would cut 48 billion over the next ten years (or about 40% of the money spent). However, Congress has not been interested in adopting Trump's proposals. While there have been many proposals over the last decade to change how the Federal government pays for GME, there haven't been substantial changes for years. No one is expecting big changes soon.

Note. This piece was based on an earlier *Forum* article: Liebow M, Jaeger J, Schwartz M. How does Medicare pay for graduate medical education? 2012;35(5):8.