

Graduate Medical Education

THE ISSUE

Some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. The president's fiscal year (FY) 2016 budget called for reducing the indirect medical education (IME) adjustment by 10 percent, which would cut Medicare medical education payments by approximately \$16.3 billion over 10 years.

In July 2014, an Institute of Medicine (IOM) committee recommended phasing out Medicare's current, separate IME and direct GME (DGME) payments to hospitals and replacing them with one geographically adjusted national per resident amount, paid to GME training program sponsors. If implemented, the recommendations would uncouple Medicare DGME funding from patient care provided to Medicare beneficiaries, allowing current hospital GME funding to go to other entities that do not treat Medicare patients and to the creation of additional government bureaucracies. According to the IOM committee's own projections, in year five of a 10-year phase out of Medicare GME funding, teaching hospitals would experience effectively a 35 percent cut

in payment for GME. The committee recommended the termination of Medicare support at the end of 10 years with no new funding source – instead simply an assessment of the ongoing need for Medicare funding. Finally, the recommendations do not adequately address the current limits on the number of Medicare-funded residency training slots when our nation is already facing a critical shortage of physicians. The report also ignores how hospitals are already addressing the changing health care landscape by providing training in outpatient settings such as community clinics; giving a common infrastructure to support all residents; and recognizing that some specialties, like neurosurgery, require training only in an inpatient environment.

The Medicare IME Pool Act of 2015 (H.R. 3292) would replace existing IME payments with a block grant payment that is paid to a hospital through a per-resident amount for cost-reporting periods ending during or after FY 2019. This legislation would significantly change how IME payments are made to hospitals and would, like the IOM's recommendations, decouple IME payment from patient care provided to Medicare beneficiaries.

AHA POSITION

Reject reductions in Medicare funding for indirect medical education and direct graduate medical education. The AHA also supports the Resident Physician Shortage Reduction Act of 2015 (S. 1148/H.R. 2124) that would add 15,000 residency positions eligible for GME and IME.

WHY?

- **Cuts to GME funding would jeopardize the ability of teaching hospitals to train the next generation of physicians.** Reductions to GME funding would have significant impact, including forcing teaching hospitals to reduce staff, close training programs and eliminate services operating at a loss. The AHA opposes proposals that would alter the GME financing structure in a way that would reduce DGME or IME payments to teaching hospitals. Reductions in Medicare financing for medical education would threaten the stable and predictable financing teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.
- **Reductions in the IME adjustment would directly threaten the financial stability of teaching hospitals.** In February 2011, the Association of American Medical Colleges estimated the impact of federal IME cuts and found that a 60 percent reduction in IME payments could mean a loss of 72,600 jobs, \$653 million in state and local tax revenue, and \$10.9 billion to the U.S. economy.

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- **The nation already is facing a critical shortage of physicians, and cuts to IME/DGME would further exacerbate the problem.** Experts indicate that the nation could face a shortage of as many as 94,700 doctors by 2025.¹ Physician shortages hamper national efforts to improve access to care and may result in longer wait times for patients.
- **Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians.** Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the cap on residency slots, set in 1997 at 1996 levels, be lifted. We urge Congress to end the freeze on the number of physician training positions that Medicare funds and support the Resident Physician Shortage Reduction Act (S. 1148/H.R. 2124), which would create 15,000 new resident positions (about a 15 percent increase in residency slots).

KEY FACTS:

Teaching hospitals serve a unique and critical role in the nation's health care system. They not only train future health care professionals, but also conduct medical research and serve a distinct and vital role in delivering patient care. They are centers of research and innovation, helping to develop new treatments and cures, and provide highly-specialized services such as burn care. Yet Medicare does not cover the total cost of care provided to Medicare beneficiaries. In its March 2016 report, the Medicare Payment Advisory Commission indicated that the overall Medicare margin was *negative* 4 percent for major teaching hospitals and *negative* 5.7 percent for other teaching hospitals.

The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs for training health professionals.

IME payments are explicitly made to compensate for the higher costs associated with teaching hospitals, such as residents' "learning by doing," greater use of emerging technology and greater patient severity. The IME payment adjustment is a percentage add-on to the hospital's inpatient prospective payment system, and it varies based on the intensity of the hospital's teaching programs as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio is capped at 1996 levels.

Congress recognized the need for the IME adjustment at the inception of the inpatient prospective payment system, noting it was necessary to "account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents..."² Congress restated the need for IME in 1999 "...to compensate teaching hospitals for their relatively higher costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals."³

DGME payments help fund the teaching costs of residency programs, such as resident salaries and benefits, faculty salaries and benefits, and administrative overhead expenses. These payments are based on a hospital-specific, per-resident cost in 1984, updated annually for inflation. The per-resident payment amount varies by the residents' specialties. The resident count for most hospitals also is capped at their 1996 levels.

According to the Centers for Medicare & Medicaid Services, there are 1,038 teaching hospitals. Teaching hospitals directly employ 2.7 million people and are often among the largest employers in their communities. They are major economic engines, generating business, employment and tax revenue.

¹ HIS, Inc. "2016 Update to The Complexities of Physician Supply and Demand: Projections from 2014 to 2025," April 5, 2016

² House Ways & Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report No. 98-23, March 11, 1983.

³ U.S. Congress, House of Representatives, Committee on Ways and Means. Medicare and Health Care Chartbook. May 17, 1999. Washington, DC U.S. Government Printing Office.