

THE ISSUE

Some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. The President's Plan for Economic Growth and Deficit Reduction calls for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately \$9 billion over 10 years. Last year, the Simpson-Bowles deficit commission recommended reducing the IME adjustment by 60 percent and limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated \$60 billion through 2020.

AHA POSITION

Reject reductions in Medicare funding for indirect medical education and direct graduate medical education.

WHY?

- **Cuts to graduate medical education funding would jeopardize the ability of teaching hospitals to train the next generation of physicians.** They would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences. The AHA opposes any cuts to graduate medical education funding, which would have a significant impact on teaching hospitals and the beneficiaries and communities they serve.
- **Reductions in the IME adjustment will directly threaten the financial stability of teaching hospitals.** In February 2011, the Association of American Medical Colleges (AAMC) 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.
- **The nation is already facing a critical shortage of physicians, and cuts to IME/Direct GME would further exacerbate the problem.** At current graduation and training rates, the AAMC projects that the nation could face a shortage of as many as 150,000 doctors in the next 15 years. The expansion of health care coverage to 32 million uninsured in 2014 is projected to require an additional 31,000 physicians. Physician shortages will 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 1996 cap on residency slots be lifted. We urge Congress to eliminate the 15-year freeze in the number of physician training positions funded by Medicare and support the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots).

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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 2011 report, the Medicare Payment Advisory Commission indicated that the overall Medicare margin was negative 0.6 percent for major teaching hospitals and negative 5.2 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 resident-to-bed ratio is capped at 1996 levels.

Direct GME 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, with higher payments for residents training in primary care. The resident count for most hospitals is capped at their 1996 levels as with IME.

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. In 2007, teaching hospitals had a total economic impact of over \$1 trillion.