

## 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) 2015 budget called 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 \$14.6 billion over 10 years. The Simpson-Bowles deficit commission recommended reducing the IME adjustment by 60 percent and limiting hospitals' direct GME (DGME) 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.

In July, an Institute of Medicine (IOM) committee recommended phasing out Medicare's current, separate IME and 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 GME 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 recommends 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.

### AHA POSITION

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

### 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 eliminate staff, close training programs and eliminate services operating at a loss. The AHA opposes any cuts to GME funding because they would result in fewer physicians being trained and reduce access to care across the country.
- **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.
- **The nation is already 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 130,000 doctors by 2025. The expansion of health care coverage would increase overall demand for physicians and would increase the projected physician shortfall by up to 31,000 physicians. Physician shortages would 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 18-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots) as included in the Resident Physician Shortage Reduction Act of 2013 (S. 577), introduced by Sens. Bill Nelson (D-FL), Harry Reid (D-NV) and Charles Schumer (D-NY).

Continued on reverse

## 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 2013 report, the Medicare Payment Advisory Commission indicated that the overall Medicare margin was *negative* 2.4 percent for major teaching hospitals and *negative* 5.4 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... ." <sup>1</sup> 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." <sup>2</sup>

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. 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.

<sup>1</sup>House Ways & Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report No. 98-23, March 11, 1983.

<sup>2</sup>U.S. Congress, 1999.