



What Does Medicare Have to Do with Graduate Medical Education?

Graduate Medical Education (GME) is the hands-on training phase of physician education that is mandatory in order for doctors to obtain a license for independent practice. After four years of college, physicians-in-training complete another four years of undergraduate medical education (medical school) to earn their M.D. degrees, and then proceed to GME (or residency) training. This training varies in length but generally lasts at least three to five years for initial specialty training; those in subspecialties may train for up to 11 years after they graduate from medical school. This training is supported by teaching hospitals, though the clinical experience occurs in a variety of settings.

AAMC members of the Council of Teaching Hospitals and Health Systems (COTH) train over 75 percent of physicians. They also represent only 6 percent of all acute-care hospitals yet provide over 20 percent of inpatient care and 40 percent of all charity care. Teaching hospitals, with their medical school partners, employ almost 1.9 million people.

Hospitals that train medical residents have direct costs that include:

- Stipends and fringe benefits of residents
- Salaries and fringe benefits of faculty who supervise the residents
- Other direct costs, such as the salaries for staff in the GME administrative offices, and
- Allocated institutional overhead costs, such as maintenance and electricity.

Medicare, through its **Direct Graduate Medical Education (DGME)** payment system, compensates teaching hospitals for Medicare's share of the costs directly related to training residents. Medicare does not make payments related to the education of medical *students*.

When Congress established Medicare in 1965, it recognized that:

Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213, 89th Congress, 1st session 32 (1965) and Senate Report, Number 404 Pt. 1, 89th Congress, 1st Session 36 (1965)).

The cost to hospitals of training a resident averages \$100,000 or more a year. Medicare's share of that cost is usually around \$40,000. **As a result, given that there are about 110,000 residents in training each year, teaching hospitals' direct costs of training are approximately \$13 billion a year. Medicare supports about \$3 billion of that total.**

Teaching hospitals also maintain an environment in which clinical research can flourish alongside training and the highest level of patient care. Because of their education and research missions, teaching hospitals are able to offer the most advanced services and equipment. Additionally, physicians of diverse specialties at teaching hospitals are available around the clock, prepared to care for the nation's most

critically ill or injured patients. These unique services and skills sets increase the cost of patient care at these institutions.

Medicare supports its share of the higher costs of patient care in teaching hospitals that are not directly related to education, but reflect the costs of treating a more complex patient population as well as highly specialized services and emergency or standby services that are unavailable elsewhere in a community (such as burn units and trauma units). All patients in a community can benefit from these services if they become severely ill, regardless of whether or not they are Medicare beneficiaries. For example, COH hospitals perform 72 percent of bone marrow transplants and house 78 percent of all burn care unit beds in the country.

Because Medicare pays teaching hospitals the same basic rate per discharge as other hospitals (which often is less than the cost of care), Congress created the **Indirect Medical Education (IME)** payment to help defray these higher patient care costs. Despite its label, **IME is a patient care payment made to teaching hospitals because they treat a more complex patient population and provide services that others can't.**

The purpose of the IME adjustment, as stated by Congress when it created the PPS in 1983, is clear:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system 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...The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, No. 98-25, March 4, 1983 and Senate Finance Committee Report, No. 98-23, March 11, 1983).

Because the current Medicare Severity Diagnosis Related Group system fails to capture these higher costs of patient care and unique services, the IME payment remains an add-on to Medicare discharge payments that varies with the teaching intensity (as measured by the ratio of physician trainees to the number of beds in a hospital). Since its inception in the 1980s, the size of that additional patient care payment has been cut in half, from an adjustment of 11.59 percent to 5.5 percent.

Currently, **Medicare supports approximately \$6.5 billion of these higher patient care costs through the IME adjustment.** Yet the *actual* cost of providing these services that benefit communities and the health and well being of patients is much higher and often unrecognized by private payers. An analysis of 1998 data published in *Health Affairs* (Koenig et al, 2003) found that **the mission-related costs of U.S. teaching hospitals are more than \$27 billion a year.** These costs have only increased over time, yet Medicare's support has been effectively capped since 1997.

Medicare's support of GME includes paying its share of the costs of training but also support for the higher costs of patient care that communities rely on when they need care the most. Without adequate support, teaching hospitals' ability to provide that care would be threatened.