Graduate Medical Education (GME)

To practice medicine in the United States, upon completion of medical school, all medical school graduates who seek full medical licensure and board certification in a medical specialty or subspecialty must complete a period of graduate medical education (GME) or residency training. GME comprises the second phase of the formal educational process that prepares doctors for medical practice. Residency programs vary in length depending on specialty, but generally last three to five years for initial board certification. Subspecialty training may extend the period to as long as 11 years following the award of the M.D. degree. At a minimum, with medical school and residency combined, it takes at least 7 years to train a doctor.

Medicare Direct Graduate Medical Education (DGME)

Clinical settings are key sites for the education of future physicians. Typically, teaching hospitals and associated ambulatory settings provide such an educational environment for the training of resident physicians (“residents”). Residents have graduated from medical school and then go on to complete several years of supervised, hands-on training in a particular area of expertise, such as primary care or surgery. This phase of their training is called “graduate medical education” (GME).

Hospitals that train residents incur real and significant costs beyond those customarily associated with providing patient care. The Medicare program makes explicit payments to teaching hospitals for a portion of these added costs through direct graduate medical education (DGME) payments.

Purpose of the DGME Payment

Medicare DGME payments compensate teaching hospitals for “Medicare’s share” of the costs directly related to the training of residents, which include:

- Stipends and fringe benefits of residents;
- Salaries and fringe benefits of faculty who supervise the residents;
- Institutional overhead costs, such as maintenance and electricity;
- Clerical personnel who work exclusively in the GME administrative office; and
- Accreditation fees.

In establishing the Medicare program in 1965, Congress 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 1 Session 36 (1965)).

DGME Payment Methodology

In general, Medicare pays each teaching hospital a portion of the hospital's "per resident amount" (PRA), which was determined by the Centers for Medicare and Medicaid Services (CMS) for each teaching hospital in the 1980’s and is updated each year by an inflation factor. The PRA represents the annual DGME costs incurred by a teaching hospital, which on average total approximately $100,000 per resident. The updated PRA is then multiplied by the hospital's resident count, subject to its cap (see below). Medicare pays its portion of this amount based on the ratio of the number of total inpatient days Medicare patients spend in the hospital divided by the hospital's total inpatient days for all patients. Generally speaking, a major teaching hospital’s Medicare share is about 30 to 40 percent of its PRA or approximately $30,000 to $40,000 per resident, per year.

As discussed above, Medicare now imposes a limit on the number of residents the program supports. The limit is based on the number of full-time equivalent (FTE) residents in approved allopathic or osteopathic training programs according to the hospital's most recent cost report period ending on or before December 31, 1996. Dental and podiatric residents are excluded from the residency limits.
Since July 1987, hospitals have been permitted to count the time that residents spend training in clinical settings outside the hospital, such as freestanding clinics, nursing homes, and physician offices, so long as the hospital incurs "all or substantially all" of the costs in the nonhospital setting, and subject to certain other requirements.

**Medicare Indirect Medical Education (IME) Payments**

Teaching hospitals receive Medicare IME payments to help offset the increased costs associated with the training of residents. For example, teaching hospitals care for sicker patient populations than non-teaching hospitals. They also assure all patients have access to highly specialized care, such as trauma centers, burn units, or neonatal intensive care units (NICUs), regardless of ability to pay, while also maintaining an environment in which clinical research can flourish. Due to their education and research missions, teaching hospitals also offer the newest and most advanced services and equipment. Additionally, the residents and supervising physicians at teaching hospitals are available around-the-clock, prepared to care for the nation's most critically ill or injured patients.

Recognizing the differences in the patient care costs between teaching and non-teaching hospitals, the Medicare program includes a special Indirect Medical Education (IME) payment adjustment in its prospective payment system (PPS).

**Purpose of the IME Payment**

Medicare IME payments carry a "medical education" label, but their purpose, as stated by Congress in creating the prospective payment system (PPS) in 1983, is much broader:

> 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 Rept., No. 98-25, March 4, 1983 and Senate Finance Committee Rept., No. 98-23, March 11, 1983).

Medicare IME payments are made in recognition of the differences in the patient care costs between teaching and non-teaching hospitals. Despite their label, IME payments are patient care payments made to teaching hospitals because they treat a more complex patient population and provide services that others cannot.

**IME Payment Methodology**

For every Medicare case paid under the operating inpatient PPS, a teaching hospital receives an additional payment, calculated as a percentage add-on to the basic price per case. The hospital's IME payment is determined by inserting its individual intern/resident-to-bed (IRB) ratio into a formula established under the Medicare statute. As a hospital's involvement in GME increases, its percentage add-on to the basic PPS payment also increases. Over 1,100 teaching hospitals receive IME payments.

Because teaching hospitals are not paid directly by Medicare for treating managed care patients, they must submit a "shadow" (no-pay) claims to Medicare to receive IME payments on behalf of these patients.

Teaching hospitals also receive an IME payment associated with Medicare's capital PPS. This payment is based on a slightly different formula and uses residents-to-average daily census (RADC) rather than the IRB to measure teaching intensity.

To Learn More about Medicare GME, visit: https://www.aamc.org/initiatives/gmefunding/

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