



Advising the Congress on Medicare issues

Graduate Medical Education Payments

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About MedPAC

- Independent, nonpartisan Congressional support agency
- 17 national experts selected for expertise
- Appointed by Comptroller General for 3-year terms (can be reappointed)
- Make recommendations to the Congress and the Secretary of HHS
- Vote on recommendations in public

History of Medicare support for graduate medical education (GME)

- Medicare has subsidized GME since its inception in 1965
 - Both direct and indirect costs associated with training physicians
 - Medical education benefits society broadly
 - Medicare should support its share of medical education costs until permanent, community-wide solution found (U.S. House 1965, U.S. Senate 1965)
- Medicare is the major source of subsidy for medical education

Medicare support for graduate medical education: Direct

- Reflects hospital-specific per resident costs in a base period, adjusted for inflation
- Based on 3 factors:
 - Hospital's updated per resident payment amount
 - Weighted count of full-time equivalent residents supported by the facility
 - Hospital's Medicare patient share, based on the ratio of Medicare patient days to total patient days in the acute inpatient setting
- Totals about \$3 billion

Medicare support for graduate medical education: Indirect (IME)

- Payment for higher patient care costs associated with teaching activities (e.g., more tests, residents learning by doing)
- Increased payment for every Medicare admission
 - Add-on percentage that increases with ratio of interns and residents to number of beds
 - Half of teaching hospitals receive add-on payments of 5% or less, while the top ten percent of hospitals receive add-ons of 27% or more
- Higher costs related to patient severity and case-mix are addressed through MS-DRGs
- Totals about \$6.5 billion

MedPAC analysis: IME payments are set too high

- Since 1983, indirect medical education payments have been set at twice the level justified by the data
- Statutory changes over the years have lowered the add-on payment from 11.8% to 5.5%
- MedPAC data analysis found that an add-on of approximately 2.2% would compensate hospitals for the increased inpatient costs of teaching - ~ \$3 billion
- Extra 3.3% amounts to ~ \$3.5 billion

Current Medicare subsidies for graduate medical education

Direct GME

\$3 billion



Resident and administrative costs

IME

\$6.5 billion



Empirically justified

Higher inpatient costs related to teaching (\$3 billion)

Extra - ??
(\$3.5 billion)

IME payments and patient severity

- Some argue that additional IME payments are needed to compensate hospitals for treating sicker patients
- Yet, IME add-on payments are computed after Medicare adjusts for case-mix and patient severity
- Implementation of a more sophisticated severity adjustment (MS-DRGs, recommended by MedPAC) in 2008/2009 benefited teaching hospitals

Medicare subsidies and residency slots

- Number of residency slots is determined by the GME community
- Hospitals benefit from employing residents: less costly labor, cache associated with being a teaching hospital
- Certain residency programs generate revenue for hospitals
- Proof of residency programs' value to hospitals: hospitals self-finance approximately 12,000 residency slots

Context for MedPAC work on GME

- Only teaching hospitals receive Medicare GME and IME payments
- Residency programs are largely based in acute-care teaching hospitals or medical schools tightly affiliated with teaching hospitals
- Residents spend most of their training time involved with inpatient care because financial incentives discourage teaching hospitals from training residents in non-hospital settings
- Yet, most of the medical conditions that practicing physicians confront are, and should be, managed in non-hospital settings (e.g., offices, nursing facilities, homes)

Summary of RAND/MedPAC study findings

- Study objective: To learn about how selected curricula are presented in internal medicine residency training programs
- Although most programs provide at least some training in selected topics essential for delivery reform, overall, curricula fall far short from that recommended by the IOM and other experts
 - Concerned about lack of formal training and experience in:
 - Outpatient care coordination
 - Multidisciplinary teamwork
 - Awareness of health care costs
 - Comprehensive health IT
 - Patient care in non-hospital settings
 - Quality measurement and continuous improvement
- Several factors affect programs' ability to train in selected topics – such as IT capabilities, faculty expertise, institutional support, etc. – some specific to residency program, and others reflect sponsoring teaching hospital

Principles for reform

- MedPAC has called for delivery system reforms to focus on coordinating care for the beneficiary, improving quality, and controlling spending
- U.S. GME system is needs to be aligned with the delivery system reforms essential for increasing the quality and value of health care
- Medical education should support these reforms by training physicians with the skills they need to deliver care in a coordinated delivery system

Recommendation #1: Establish performance-based payments for GME

- The Congress should authorize the Secretary to establish a performance-based incentive program with payments to institutions contingent on reaching desired educational outcomes and standards
 - Panel of individuals and stakeholders with expertise and relevant perspectives should advise the Secretary
 - Eligible institutions to include teaching hospitals, medical schools, and other entities sponsoring residency programs
 - Funding should come from reducing IME payments to eliminate the amount paid above empirical IME costs
- Goal: Foster greater accountability for Medicare's GME dollars and reward education and training that will improve the value of our health care delivery system

Recommendation #2: Increase the transparency of Medicare's GME subsidies

- The Secretary should annually publish a report that shows, by hospital, the amount of funding received in Medicare GME payments and associated costs
 - Interpreting reported cost data may require some caveats
- Goal: Encourage collaboration between educators and institutions on residency program funding decisions and recognize Medicare's significant investment in residency (and some nursing) training and education

Recommendations for studies

1. Identify workforce needs for a high-value, affordable health care delivery system
2. Analyze how residency programs affect the financial performance of their affiliated institutions and whether Medicare should support programs in all specialties equally
3. Determine a strategy for increasing the diversity of our health professional workforce; report on what programs are most effective to achieve this pipeline goal