Federal Funding of Graduate Medical Education

Congress has grappled with a number of modifications to the Medicare program this year. Public concern regarding the future financial solvency of Medicare as well as growing apprehension about the increased size of the physician workforce prompted policymakers to reevaluate the funding of graduate medical education (GME).

The House Commerce Committee, the House Ways and Means Committee, and the Senate Finance Committee each presented their recommendations in separate bills to reform GME.

House and Senate Proposal Similarities
Several GME provisions were identical in all three bills. All three committees limited Medicare spending for fiscal year 1998 for full-time residents in approved medical training programs to spending at the fiscal year 1996 level. In addition, they imposed a mechanism to lower future spending for medical residents. The bills create a “rolling average” by averaging the amount spent by Medicare on residents in the current fiscal year and the previous two fiscal years. For example, in 1999, the funding level would be determined by averaging the amount spent by Medicare for residents for fiscal year 1998 (capped at the 1996 level), with the funding for 1997 and 1996. In future years, the rolling average would continuously reduce the total spending for medical residents.

In addition, all three bills direct the Secretary of Health and Human Services to develop guidelines for making direct medical education (DME) payments to nonhospital providers. Current law allows a nonhospital facility to receive funding only if it has established a joint agreement with a teaching hospital. The provision under consideration would permit federally qualified health centers, rural health clinics, and newly created MedicarePlus organizations, which offer more options in health care delivery to beneficiaries, to receive DME funding directly under Medicare.

Further, both the House and Senate agreed to the establishment of an independent advisory panel called the Medicare Payment Advisory Commission (MEDPAC). MEDPAC would study the physician workforce, funding for international medical graduate residents, and the possible use of an “all-payor” system for GME. In an all-payor system, everyone who benefits from the process of training medical residents would be assessed a fee that would be used to fund medical training costs.

The belt tightens. Congress has mandated reductions in funding of the training of medical residents.

Committee Differences on GME Policy
The House and Senate Committees differed on a number of other provisions related to GME.

Overhead Costs
Direct medical education payments to teaching hospitals contribute to overhead costs in addition to direct expenses associated with the training of residents. Overhead costs include maintenance and equipment repair and may vary among different teaching hospitals. The House bills would penalize teaching hospitals whose overhead costs exceeded the 75th percentile of all teaching hospitals. The Senate Finance Committee bill did not include any provisions to address overhead payments.

Voluntary Reductions in the Number of Residents
While the House and Senate were identical in their approach to reduce funding for residents, only the House plan provided incentives for voluntary reductions. If a teaching hospital agreed to reduce its trainee rolls by 20% to 25% during a period of five or six years, it would receive a transition payment. This payment is intended to help
hospitals adjust to lower levels of funding for training residents. The House proposal is modeled after a demonstration project for New York teaching hospitals that was approved by the Health Care Financing Administration earlier this year.

**Indirect Medical Education**
Indirect medical education (IME) payments are provided to teaching hospitals in recognition that their health care costs generally are higher than nonteaching hospitals. The committees differed over reductions in these payments. The House Ways and Means Committee chose to lower the IME adjustment from 7.7% to 5.5%, phased in during a two-year period. The Senate proposal also reduces IME payments to 5.5%, but does so during a five-year period. The House Commerce Committee did not include this provision in its budget bill.

**Managed Care Payment Formula Under Medicare**
Medicare uses the average adjusted-per-capita cost (AAPCC) to project the average costs incurred by each Medicare beneficiary enrolled in the fee-for-service program. Medicare includes the costs teaching hospitals incur under DME and IME in this calculation. Medicare also bases capitation payments made to managed care plans on the AAPCC estimate for fee-for-service. Under current law, managed care providers are not required to pass the DME and IME portions of capitation payments on to hospitals. Teaching hospitals are concerned that managed care plans are receiving payment for services they do not provide.

The House Commerce Committee and the Senate Finance Committee included a provision to separate or “carve out” the DME and IME portion from capitation payments made to managed care plans and pay it directly to teaching hospitals. The House Ways and Means Committee did not include a carve-out provision.

**Final GME Provisions**
After meeting for several weeks in July, members of the Senate and House met to reconcile differences among budget proposals and finalize the GME provisions for the Medicare budget bill. These provisions were combined with the tax portion of the Balanced Budget Act of 1997 and passed by Congress. The final GME provisions included the following:

- DME and IME payments will be carved out from payments to managed care plans over a five-year period and made directly to teaching hospitals. In 1998, 20% will be paid to teaching hospitals; in 2002, 100% will go to these hospitals.
- Hospitals will be provided with voluntary incentives to reduce the number of medical residents.
- The IME adjustment will be lowered to 5.5%. The rate will be 7.0% for 1998, 6.5% for 1999, 6.0% for 2000, and 5.57% for 2001 and thereafter.
- Funding for resident positions will be capped at 1996 levels and subsequently lowered through the use of the rolling average.
- The Secretary of Health and Human Services will develop guidelines for DME payments to nonhospital entities.

**Conclusion**
Lawmakers made it clear early in the budget process that no government agency or program would be exempt from budget cuts. It is important to keep in mind that while the budget reduces DME and IME payments, Congress could not cut $115 billion from the Medicare program without some sacrifice. ASCP will continue to work with Congress to ensure that the future mission of medical education is maintained, adequate funding levels are preserved, and quality medical education is available to all who choose to enter the field.

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**The Language of Medicare**

**Average adjusted-per-capita cost (AAPCC)**—the method Medicare uses to calculate the capitation payments made to risk-contracting plans or managed care arrangements; it is based on expenditures made under the Medicare fee-for-service program on a county-by-county basis, including spending for DME, IME, and DSH payments.

**“Carve out”**—the method by which teaching hospitals could secure direct DME, IME, and DSH payments; under current law, managed care plans receive capitation payments that include this funding but are not required to support teaching hospitals.

**Direct medical education (DME)**—funding under Medicare provided to teaching facilities for costs associated with teaching medical students, including resident stipends, faculty salaries, and classroom expenses.

**Disproportionate-share hospitals (DSH)**—medical institutions, often teaching hospitals, that are paid a Medicare adjustment because they serve a larger number of poor patients.

**Indirect medical education (IME)**—a Medicare adjustment paid to teaching hospitals, which generally treat more poor patients, provide more uncompensated care, and use more expensive technologically advanced equipment than nonteaching hospitals.