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Medicare Direct Graduate Medical Education (DGME) Payments

Introduction

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

The DGME payment compensates teaching hospitals for “Medicare’s share” of the costs directly related to the training of residents. Medicare does not make payments related to the clinical education of medical *students*. The added direct costs of GME incurred by teaching hospitals include: stipends and fringe benefits of residents; salaries and fringe benefits of faculty who supervise the residents; other direct costs; and allocated institutional overhead costs, such as maintenance and electricity. Other direct costs include, for example, the cost of clerical personnel who work exclusively in the GME administrative office.

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 1 Session 36 (1965)).

DGME Payment Methodology

In general, Medicare pays each teaching hospital a portion of the hospital’s “per resident amount” (PRA). As further described below, the PRA represents the DGME costs incurred by a teaching hospital in a base period (generally 1984 or 1985) divided by the number of full-time equivalent (FTE) residents during that base year. The PRA is updated annually by an inflation factor and 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.

In general, each hospital has two separate PRAs because in Fiscal Years (FYs) 1994 and 1995 the PRAs for non-primary care residents were not updated for inflation, while the primary care PRAs were updated. Thus, each teaching hospital receives slightly higher payments for residents training in primary care specialties and slightly lower amounts for residents in other specialties. Primary care specialties include family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, osteopathic general practice, and obstetrics/gynecology.

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In addition, the program pays lower amounts for residents in subspecialties. For training periods beyond the years required for a resident's initial board certification in his/her first specialty (not to exceed a maximum of 5 years), the Medicare DGME payment is reduced by 50 percent. The 50 percent payment continues indefinitely, as long as the resident remains in an approved program (ie, certified by the appropriate accrediting body).

The period for full payment may be extended up to two years for additional training if it occurs in a geriatric or preventive medicine residency or fellowship. For "combined" primary care residency programs (eg, internal medicine/pediatrics), the BBA of 1997 defined the period for full DGME payment as the minimum number of years of formal training required to satisfy the initial board requirements of the longest program, plus one year.

As discussed above, Medicare now imposes a limit on the number of residents it supports. The limit is based on the number of FTE residents in approved allopathic or osteopathic training programs, before application of the 50 percent weighting factor, 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 allowed to count the time that residents spend in 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.

Selected Legislative History

Since the inception of the Medicare program, the federal government has paid its proportionate share of the direct costs associated with GME. The remaining costs are financed by a variety of sources such as Medicaid, the Departments of Veterans Affairs and Defense, state and local government appropriations, faculty practice plans hospital revenues, and philanthropies. From 1965 until the mid 1980s, Medicare paid for its share of DGME costs based on each hospital's historical, "Medicare-allowable" costs. Reimbursement was open-ended: if a hospital increased its DGME costs, the Medicare program would pay its share of the actual allowable costs incurred.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-272), which dramatically altered the DGME payment methodology in two ways. First, Medicare uncoupled the relationship between "open-ended" GME costs and DGME payments by paying each hospital based on its DGME costs incurred in a base year period (1984 or 1985) divided by the number of residents counted in the base year (the PRA). The program audited each hospital's reported costs to establish this hospital-specific PRA. The hospital's DGME payments are based on this PRA updated annually by a set inflation factor, regardless of the hospital's actual GME costs in a given year. Second, the Medicare program limited the number of years for which it would fully support its share of residency training costs, by paying only 50 percent of the calculated amount for fellowships. In August 1993, Congress again modified the DGME payment methodology (P.L. 103-66), making slight adjustments to the existing COBRA methodology.

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) made several changes to the DGME payment methodology. It placed limits on the number of FTE residents that hospitals can count for DGME payments and also that the DGME payments be based on a resident count that reflects a three-year rolling average methodology. The BBA also provided that the Medicare "share" would reflect Medicare managed care patients (previously, only inpatient days associated with fee-for-service patients was recognized).

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (P.L. 106-113) established a "floor" for hospital PRAs. Effective FY 2001, BBRA set the floor at 70%, of a locality-adjusted national average PRA. Under the "Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000" (P.L. 106-554), the floor was reset at 85 percent. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. (P.L. 108-173) provided that hospitals with PRAs above 140 percent ceiling of the locality-adjusted national average would not receive updates through FY 2013.