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Findings Brief:

MEDICARE GRADUATE MEDICAL EDUCATION PAYMENTS TO RURAL HOSPITALS

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Graduate medical education (GME) programs located in rural areas can help counteract persisting rural physician shortages by attracting medical residents and physicians to rural communities. Medicare is the single largest payer providing explicit GME funds to training hospitals. This *Findings Brief* reports on the urban-rural division of Medicare GME payments, describes rural hospitals that receive Medicare GME payments, and discusses the implications of the Balanced Budget Act of 1997 for rural GME funding.

Of the roughly $6.4 billion in Medicare GME payments that were made to short-term general hospitals in Prospective Payment System (PPS) Year 12 (hospital fiscal years that began between October 1, 1994 and September 30, 1995) only 1.1% ($70.5 million) was paid to hospitals located in nonmetropolitan counties, and only 1.5% of all residents trained in these hospitals. Three large rural training programs accounted for almost half of the residents and GME payments.

MEDICARE GRADUATE MEDICAL EDUCATION PAYMENTS

Under Medicare's Prospective Payment System, GME funding is provided through one or both of the following payments—Direct Medical Education (DME) payments and Indirect Medical Education (IME) adjustments. DME payments help cover the direct costs of operating a GME program, including resident salaries and benefits, the salaries of supervising physicians, the cost of office space, and other overhead. The payments are per-resident amounts based on a hospital's historical per-resident costs from Fiscal Year 1984, updated to account for inflation, and prorated based on the hospital's proportion of Medicare patient days to total patient days. In PPS Year 12, DME payments to teaching hospitals totaled about $1.75 billion, with rural hospitals receiving only $21 million (1.2%).

Indirect Medical Education payments, made as an adjustment to a hospital's Diagnosis-Related-Group (DRG) payment, reflect the added patient care costs associated with teaching hospital settings. The IME adjustment increases the DRG payment for each Medicare admission by approximately 7.7% for each 10% increase in the resident-to-bed ratio. In PPS Year 12, IME adjustment accounted for just over 6% of Medicare's total PPS operating payments, totaling roughly $4.65 billion, with $49.4 million (1.1%) going to rural hospitals.

RURAL HOSPITALS THAT RECEIVE MEDICARE GME PAYMENTS

Seventy hospitals out of 2,241 short term non-federal general hospitals located in nonmetropolitan counties (3.1%) received Medicare GME payments in PPS Year 12. This compares to 1,069 hospitals out of the 2,823 hospitals located in metropolitan counties (37.9%). Sixty of the 70 hospitals received both DME and IME, eight received only IME and two received only DME.[1] The number of rural hospitals receiving Medicare GME payments has not grown appreciably in recent years.

[1] The two components of Medicare GME payments are not necessarily paid to the same hospital. DME payments are made to the institution which incurs "all or substantially all" of the resident's stipend and benefit costs. If a rural hospital hosts a resident on rotation from a larger sponsoring program, but the larger program continues to underwrite the stipend costs of the resident, then the DME payment will be made by Medicare to the sponsoring program. In contrast, IME payments are made to the hospital where the resident is rotating, regardless of funding arrangements for that resident's stipend. Most hospitals eligible for DME payments should also be eligible for IME payments, provided the residents are rotating in an inpatient acute care setting. Hospitals receiving DME but not IME are probably experiencing temporary payments problems as new programs.

Figure 1

Bed-size of Rural Hospitals Receiving Medicare GME Payments

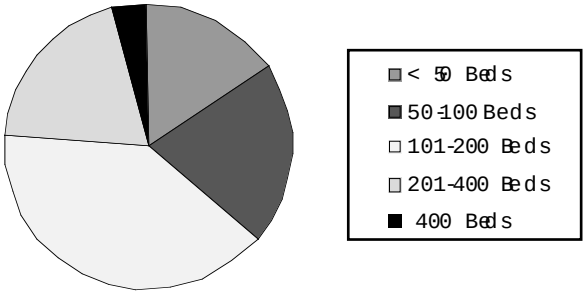
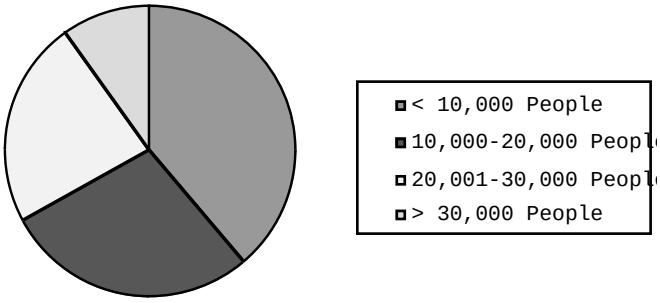


Figure 2

Population of Towns Where Rural Residents are Trained



Almost 94% of rural hospitals receiving Medicare GME payments in PPS year 12 are not-for-profit or governmental. In PPS Year 12, rural hospitals receiving Medicare GME were most likely to have between 101-200 beds (40%), but ranged from the very small to the very large (Figure 1).

Similarly, the 70 hospitals are located in rural towns of all sizes (Figure 2), and residents are being trained in the smallest rural towns. In PPS Year 12, there were 1,158 residents being trained in hospitals located in nonmetropolitan counties, compared to 78,449 residents in metropolitan counties. The average yearly Medicare DME payment per resident trained in rural hospitals was $18,391, as compared to $22,168 for metropolitan-based residents. Almost 49% of the rural residents are accounted for by three institutions with the largest programs—Geisinger Medical Center, West Virginia University Hospitals, and Mary Hitchcock Memorial Hospital.

LEVEL OF MEDICARE GME FUNDING RECEIVED BY RURAL HOSPITALS

Despite the small number of rural hospitals that have Medicare GME-funded resident training programs, the amount of payment received by these hospitals is not insubstantial. In PPS Year 12, 70 rural hospitals received a total of over 70 million dollars, over $31 million of which (44.6%) went to the three largest programs. For most rural hospitals receiving GME dollars, these funds represent a very small percentage of their total in-patient payments from Medicare, with the mean fluctuating between five and six percent across the last six years. However, for the three hospitals with the largest programs, Medicare GME funds represented 26-27% of their payments from Medicare in PPS year 12. Total Medicare GME payments to hospitals in nonmetropolitan counties are not evenly distributed across the country. States in the northeast and the Great Lakes regions of the United States receive significantly larger amounts of GME funds than do those in the rest of the country (Figure 3, Table 1).

THE BALANCED BUDGET ACT OF 1997

Prior to the recently enacted Balanced Budget Act of 1997 (BBA), Medicare GME supplemental payments were open-ended. Hospitals with accredited training programs were able to increase the number of residents in any specialty and Medicare payments (both DME and IME) increased accordingly, so long as the training positions were approved by the appropriate accreditation body for that specialty.

The BBA contains several provisions concerning Medicare GME payments that may affect rural hospitals in the near future. Most importantly, the BBA calls for the gradual reduction of IME payments to be provided to facilities training residents, and a ceiling to be phased in on the number of residents for which a GME program will receive Medicare funding. For the purpose of determining both IME and DME payments, existing programs may not exceed the number of resident FTEs reported in their teaching hospital's most recent cost report period, ending on or before December 31, 1996. Although the cap on the number of residents will restrict new expansion of residency programs in general, there has been recognition of the importance of graduate medical training programs to rural areas. This recognition is reflected in provisions in the BBA that specifically instruct the Secretary of Health and Human Services to "give special consideration to facilities that meet the needs of underserved rural areas." (P.L. 105-33 §4623 (H)(I)) While discretion is also given to the Secretary to modify the ceiling for new GME programs (those established on or after January 1, 1995), it remains to be seen how often the Secretary will provide exceptions to the cap.

Of possible benefit to rural hospitals are provisions that expand the range of providers who are eligible to be included for GME payments. For example, Medicare can now make payments to rural health clinics and federally qualified health centers for the direct costs of medical education, if these organizations bear all, or substantially all of the costs of training. If the hospitals continue to bear the costs of training, hospital-based GME programs will now be able to include time spent training in all ambulatory settings when counting the number of full-time-equivalent (FTE) residents for IME payments. Because of the cap placed on the total number of FTEs that can be claimed for IME, this provision will not result in increased payments for most programs already rotating residents to ambulatory settings. The provision does remove a significant financial barrier that previously discouraged programs from transferring training to ambulatory sites. Many of the hospitals that have been granted exceptions to the FTE cap will be in a stronger position to benefit from this change.

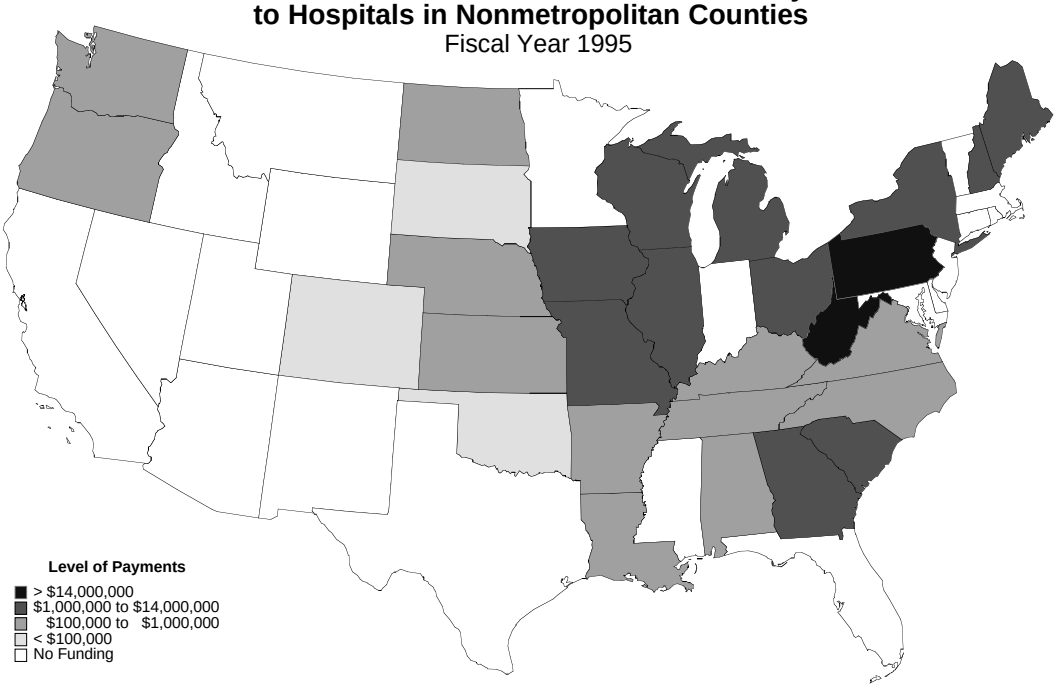
Unfortunately, the protections that are found in the BBA do not extend to metropolitan hospital-based programs that rotate residents through rural hospitals. As the number of rural-based residency programs is small, the fact that urban-based programs with rural rotations do not come under special protections may seriously restrict the number of residents who experience rural training in the future. Taken together, the change in GME payment and in how residents are counted offer both promise and uncertainty for rural training. It may be quite some time before the full effect of the Balanced Budget Act on rural training programs is known, as residency programs sort through the new regulations and begin putting them into place.

Table 1 Medicare GME Payments, by State

State	Total GME Payments	GME Payments to Nonmetropolitan Hospitals	Percent of Total GME Payments to Nonmetropolitan Hospitals
Alabama	54,421,568	658,867	1.2%
Alaska	0	0	0.0%
Arizona	55,665,520	0	0.0%
Arkansas	20,270,676	423,326	2.1%
California	337,603,104	0	0.0%
Colorado	33,361,056	15,351	0.0%
Connecticut	170,016,672	0	0.0%
Delaware	25,184,010	0	0.0%
Washington, D.C.	92,755,152	0	0.0%
Florida	124,233,296	0	0.0%
Georgia	95,396,152	1,951,130	2.0%
Hawaii	9,970,717	0	0.0%
Idaho	1,717,798	0	0.0%
Illinois	331,363,584	1,023,077	0.3%
Indiana	85,982,760	0	0.0%
Iowa	37,961,136	2,168,664	5.7%
Kansas	36,062,264	643,015	1.8%
Kentucky	38,164,516	813,577	2.1%
Louisiana	46,365,272	178,743	0.4%
Maine	18,828,334	2,431,293	12.9%
Maryland	112,684,088	0	0.0%
Massachusetts	303,961,600	0	0.0%
Michigan	439,527,520	2,347,512	0.5%
Minnesota	122,019,648	0	0.0%
Mississippi	7,607,978	0	0.0%
Missouri	176,872,704	1,768,836	1.0%
Montana	0	0	0.0%
Nebraska	26,376,688	367,052	1.4%
Nevada	5,732,598	0	0.0%
New Hampshire	5,180,143	4,808,394	92.8%
New Jersey	236,847,280	0	0.0%
New Mexico	10,519,630	0	0.0%
New York	1,279,277,312	6,536,880	0.5%
North Carolina	173,621,568	286,329	0.2%
North Dakota	5,514,106	755,559	13.7%
Ohio	416,362,464	1,258,542	0.3%
Oklahoma	33,925,132	17,863	0.1%
Oregon	28,925,200	942,151	3.3%
Pennsylvania	652,757,248	20,463,412	3.1%
Rhode Island	54,339,484	0	0.0%
South Carolina	39,921,040	1,618,324	4.1%
South Dakota	5,193,269	13,982	0.3%
Tennessee	111,125,936	567,867	0.5%
Texas	195,218,704	0	0.0%
Utah	20,144,572	0	0.0%
Vermont	14,905,600	0	0.0%
Virginia	108,547,408	320,637	0.3%
Washington	65,071,064	209,968	0.3%
West Virginia	36,921,856	14,851,668	40.2%
Wisconsin	94,786,864	3,034,778	3.2%
Wyoming	2,417,257	0	0.0%
Total	6,401,629,548	70,476,797	1.1%

Total Medicare Graduate Medical Education Payments to Hospitals in Nonmetropolitan Counties

Fiscal Year 1995



Source: Health Care Financing Administration Hospital Cost Report Information System Minimum Data Set, PPS XII, 1995.

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No nonmetropolitan hospitals in Alaska or Hawaii receive Medicare GME payments.

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