

GME FINANCING IN THE ERA OF RESIDENCY REFORM, INNOVATION, AND QUALITY IMPROVEMENT

CHAPTER OVERVIEW:

- The basis for and current status of GME financing.
- Answers to several frequently asked questions about GME financing.
- How GME resources might be more effectively utilized to support innovative models of residency redesign.

Prior to the initiation of the Medicare Program in 1965, hospitals directly financed graduate medical education (GME) and recouped the costs of this activity from inflated patient charges, including insurance payments. Medicare accepted similar responsibility for GME by paying higher charges to teaching hospitals rather than non-teaching hospitals, in large part due to the perception that teaching hospitals provided higher quality care. In addition, Medicare coverage was expected to increase the demand for medical services leading to a physician shortage.

The House of Representatives and Senate subsequently set forth the following as a guiding principle for the basis of GME financing (1):

“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 considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program (2).”

However, the rules governing Medicare payments from GME are complex and often conflict with educational priorities. As Medicare becomes less fiscally solvent, program directors must be knowledgeable about GME financing to effectively collaborate with medical school and teaching hospital administrators so they can function efficiently in the current environment. Understanding the fundamentals of GME financing will allow program directors to consider the costs of programmatic changes and strategize ways to align institution and program priorities.

Health care has changed dramatically in the past 2 decades. Yet the structure and financing of GME

have not kept pace with these changes. Due to preferential payment for inpatient services, residency training has remained predominantly an inpatient educational experience. Nonetheless, program directors are responsible for ensuring that residency training experiences achieve the fundamental objective of GME: providing residents with the knowledge and skills needed for their future practice.

For most internists, ambulatory experiences are more representative of the environment in which most residents will ultimately care for patients. In addition to ambulatory experiences, physicians-in-training require a comprehensive range of experiences if they are to provide safe, timely, efficient, effective, and cost efficient care to their patients in a variety of non-hospital settings. Thus, the program director needs the latitude and resources to provide innovative curricula in a variety of training venues.

BACKGROUND: WHO PAYS AND WHO DOESN'T

Payment for GME is explicitly made by a variety of sources, including Medicare Part A, some state Medicaid programs, the Veterans Administration, and the Department of Defense, along with entitlement and Title VII sources. Commercial 3rd-party payers do not explicitly support GME. However, one analysis recently estimated that private payers implicitly contribute approximately \$7.2 billion to GME through higher reimbursements to teaching hospitals (3). Adding this amount to public funding, about \$22 billion is currently available to meet the costs of GME, including resident stipends and benefits, faculty time, and allocated overhead costs (4).

This support amounts to approximately \$220,000 per year for each resident considered a full time employee (FTE). The approximate GME funds allocated to each institution can be determined by exploring the data

tables on the Robert Graham Center website (www.graham-center.org) (5).

The cost of educating a resident, including salary, fringe benefits, and fixed and variable costs, is estimated to range from \$70,692 in large programs to \$95,143 in smaller ones (6). Thomas J. Nasca, MD, and colleagues, estimated the fixed and variable components of the administrative and non-resident salary costs to range from \$26,610 in larger programs to \$51,061 in smaller ones (6). This discrepancy is in large part due to economies of scale for various fixed costs including personnel support, which is lower when averaged over increasing numbers of housestaff.

Figure 1 outlines an abbreviated timeline describing the history of GME funding. Major events and legislation are highlighted below to provide a perspective and appreciation of the volatility for GME support.

1965—Medicare was enacted in 1965. A portion of the patient care payment was allotted to support GME in an effort to insure the delivery of quality care to beneficiaries. These payments were made directly to the hospital sponsors of GME programs in a cost-based reimbursement fashion, described as a “pro rate” share or allowable cost. (For example, if a given hospital had an overall 33% use by Medicare patients, then GME reimbursement was 33% of the cost.) This cost-based reimbursement provided powerful financial incentives for residency program growth.

1982—The Tax Equity Finance Reconciliation Act (TEFRA) of 1982 allocated additional payments for GME costs in teaching versus non-teaching hospitals.

1983—The prospective payment system (PPS) was enacted. PPS shifted Medicare payments for GME from cost-based reimbursement to a system utilizing diagnostic related groups (DRGs). In addition, the GME allotment was split into 2 portions: the direct graduate medical education (DGME) payment and the indirect medical education (IME) adjustment.

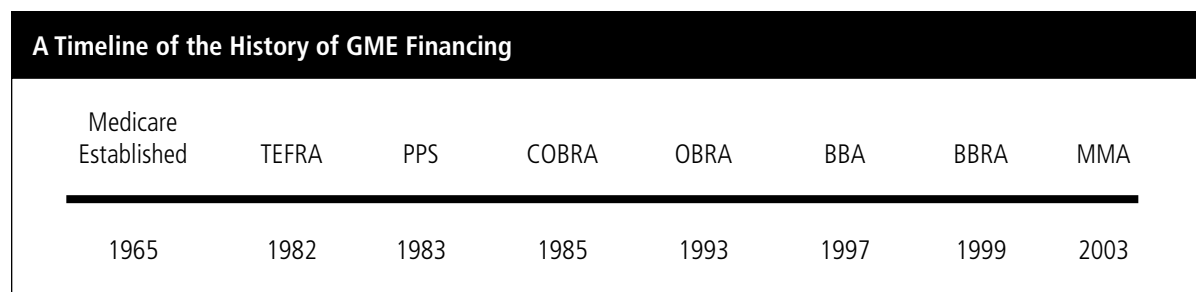
The DGME component of the Medicare Part A payment supports those costs that can be allocated to education: the salary and fringe benefits of residents and supervising faculty, the administrative costs of GME programs, and allocated institutional overhead costs (library, HVAC, electricity, etc). The DGME per resident amount (PRA) for a particular hospital was based upon data provided by hospitals on the costs of GME in fiscal year (FY) 1984. This methodology resulted in wide variability of PRAs across teaching hospitals.

The IME adjustment is not a distinct payment, but rather an inflator of the clinical care DRG payment. The basis for IME adjustment was the assumption that additional operating expenses were incurred by teaching hospitals sponsoring GME programs. These expenses originally included a higher indigent patient load, the clinical inefficiency of physicians-in-training, increased utilization of resources, additional support for the academic infrastructure, and a patient severity index not accounted for by DRGs. The IME component is calculated using the hospital’s resident-to-bed (IRB) ratio as a proxy for teaching intensity and is typically reported as a percent add-on to a DRG payment. To ensure passage of the legislation, the initial percent add-on was set at twice the actual estimated costs, or 11.1% for every 10 residents per 100 beds. A schedule for gradually decreasing the percent add-on was included in the legislation.

Finally, both IME and DGME depend upon the percentage of Medicare patients cared for at a particular institution. Teaching hospitals with a high percentage of Medicare patients receive substantially more than hospitals with lower Medicare volumes.

1985—The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 mandated that the inpatient setting was required to qualify for DGME payment. This legislation also specified that the base-year expense was to be calculated from the cost reports from fiscal year (FY) 1984 (resident counts and costs).

FIGURE 1



Finally, the hospital's DGME payment would remain unchanged through 1999, except for yearly adjustments based upon the consumer price index (CPI).

COBRA also limited DGME payments to the length of training necessary to achieve initial board certification to a maximum of 5 years. Individuals in training for longer than this initial training period (e.g., 3 years for internal medicine) would be reimbursed at a 50% rate (exceptions included residents training in geriatrics or preventive medicine).

This legislation also established the Council on Graduate Medical Education (COGME) to serve as an advisor to the Department of Health and Human Services (HHS).

1993—The Omnibus Budget Reconciliation Act (OBRA) of 1993 eliminated the yearly adjustments based upon the CPI to the per-resident DGME amount except for individuals training in primary care specialties for FY 1994.

1997—The Balanced Budget Act (BBA) of 1997 froze or “capped” the number of resident positions for which Medicare will pay at the level reported by hospitals to Medicare in FY 1996 cost reports. Hospitals with more residents than the number in place at the end of 1996 receive no DGME payment for the additional residents. Adjustments to the cap were permitted for new programs, newly affiliated programs, and primary care residents in rural areas.

1999—In an effort to reduce the wide variability in the DGME PRA, the Balanced Budget Refinement Act (BBRA) of 1999 set the range for PRA to between 70% and 140% of the mean.

2003—The Health Care Financing Administration (HCFA)—now Centers for Medicare & Medicaid Services (CMS)—further altered these aforementioned rules with the 2003 Medicare Prescription Drug Improvement and Modernization Act (MMA), which increased the IME add-on transiently to 6%, followed by decreases to 5.5% in 2008.

At this time, most people believe that federal financing of a share of GME is appropriate because producing a physician workforce is a public good; however, this idea is not universally accepted. In the mid-1990s, the Medicare Payment Advisory Commission (MedPAC) was asked by Congress to explore whether federal policies regarding GME allocation should be changed. MedPAC analysis raised questions about

whether Medicare should continue to explicitly support physician education and this discussion is again being contested in Congress as the Medicare budget becomes increasingly problematic.

FREQUENTLY ASKED QUESTIONS

Can resident “didactic” time be counted for IME and DGME payments?

Resident time spent in didactic activities, such as lectures, cannot be counted toward resident FTE count for DGME and IME purposes if such conferences are scheduled for the entire day. CMS recently announced this “one workday threshold.”

When residents rotate at “off-site” ambulatory locations of an independent practitioner, can their FTEs be included in the hospital's Medicare cost report?

Prior to July 1, 2007, to “count” a resident FTE for DGME and IME payment purposes, the resident had to be based at the hospital claiming the reimbursement. BBA permitted rotations to physicians' offices if an agreement existed to cover the costs of the resident. Responding to objections about limited opportunities for residents to train in ambulatory settings, CMS recently altered the rule for GME payments at these sites. The final rule, which went into effect July 1, 2007, will allow teaching hospitals to count these residents when calculating Medicare GME payments provided that they cover 90% of costs associated with training the residents at the non-hospital site. The rule also allows hospitals to use national salary data to estimate the cost of teaching physicians' time and clarifies how institutions should approximate the teaching (and supervision) effort for physicians in non-hospital settings.

Can Medicare Part A funds be used to cover resident time spent participating in research?

Resident training in all areas of the hospital complex may be counted in DGME costs. However, they may only be counted in the IME calculation of FTE residents for time spent in onsite patient care activities.

METHODOLOGY FOR CALCULATING DGME PAYMENT

To calculate the DGME payment for a program, multiply the hospital-specific PRA by the number of residents in the program who are still in the first 3 years of training or are participating in a fellowship in

geriatrics. Include a 50% payment for those residents beyond their first 3 years of training, but remember that there is no payment for residents beyond the institutional cap for positions. This amount is then multiplied by the percent of inpatient Medicare days.

Figure 2 provides an example of an internal medicine residency that has 50 residents all within their first 3 years of training, with a hospital-specific resident DGME payment of \$60,000, and Medicare PPS patients representing one-third of the inpatient days.

As mentioned previously, physicians-in-training in internal medicine beyond 3 years of residency are financed at a 50% FTE rate. Generally, physicians participating in fellowships (with the exception of geriatrics) are included in this category.

GME FUNDING: CURRENT AND FUTURE MODELS

John Q. Young, MD, and colleagues, noted that Medicare, although the largest fiscal supporter of GME, was perhaps the most important barrier to producing an appropriately sized, balanced, and skilled physician workforce (8). In this article, the authors recommend basing GME funding upon actual expenditures, distributing funding more uniformly, and requiring that all health insurers contribute to GME training.

Eugene C. Rich, MD, and colleagues, outlined several other problems with the current GME financing system, particularly as it relates to DGME, including included wide and idiosyncratic variability in per-resident payment amounts across institutions; no meaningful re-evaluation of PRAs since 1983; payments made directly to teaching hospitals rather than GME educators; and failure to tie GME payment to actual expenditures and to require accountability in terms of educational and clinical outcomes for how public monies are spent. (9)

The 2000 COGME report recommended the creation of a GME fund to supplement current federal funding with explicit funding from all 3rd-party payers (10). Further, this report recommends that payments for direct GME costs should be made directly to

program sponsors who must comply with educational and workforce objectives. The report goes on to recommend that payments be made to all clinical training sites to support higher patient care costs attributable to teaching activities.

CONCLUSIONS AND RECOMMENDATIONS

Understanding these fundamental GME financing issues can help program directors negotiate with their institutions about needed changes to their programs. The costs of moving residents into different educational venues include losses in revenue if the new activity results in a decrease in the hospital's FTE count; replacement costs for resident service and teaching responsibilities; and increased teaching costs if the activity requires curriculum development, additional faculty time, and outcomes assessment. Teaching hospitals have become increasingly corporate-minded and the hospital chief executive officer's primary responsibility remains fiduciary. Therefore, hospitals are unlikely to incur such costs unless the proposed programmatic changes work to their benefit in some way.

Program directors will need to better understand their institution's strategic plan and priorities to determine how to align educational changes to programs that benefit the hospital. As an example, most institutions have launched major quality improvement initiatives, often without significant resident involvement. Yet, residents are required to demonstrate competence in practice-based improvement and systems-based practice. Program directors are more likely to be successful at negotiating support for new educational activities if they link these new activities to the institution's overall quality improvement program.

Such efforts will not resolve all of the problems with the current GME funding system, particularly since the Medicare trust fund is expected to begin posting net losses by 2010. However, working in this manner may allow program directors to make incremental changes to better provide the knowledge and skills required for future independent practice. In the meantime, new legislation is sought that will resolve the more

FIGURE 2

Sample Calculation of Medicare Payment of DGME (7)			
50 residents x \$60,000 per resident	x	50,000 Medicare PPS Days	= \$1,000,000/year
		150,000 Total Hospital Days	

intractable problems with the current funding model. Several alternative models have been proposed and are currently being considered at the national level. However, as this debate unfolds, program directors will need to remain informed and work with their institutions to understand the implications for their training programs.

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