

Graduate Medical Education Funding



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Medicare and Graduate Medical Education

Plus a brief overview of other sources of funding

The federal government funds Graduate Medical Education (GME) through the Medicare program. Therefore legislation involved in allotting funds to teaching hospitals has a direct effect on the number of residency positions, ability for residents to switch specialties, patient population during training, and the quality of training. The total estimated spending on Direct Graduate Medical Education (D-GME) and Indirect Medical Education (IME) for 2003 is estimated is 2.59 and 5.30 billion dollars respectively.

A. Current laws concerning Medicare's funding of graduate medical education have the power to:

1. Prevent hospitals from creating new residency programs by instituting caps on the number of residents per hospital.
2. Cause hospitals to close residency programs if reimbursement is not high enough.
3. Increase opportunities for health care access in rural areas by redistributing residency slots to rural hospitals.
4. Encourage training of residents in primary care, preventive medicine, and geriatric specialties.
5. Prevent residents from switching to longer specialties by imposing a loss of funding to the teaching hospital.
6. Encourage rural and low-income patient populations in graduate medical education (the later is actually loosely correlated to Disproportionate Share (DSH) payments and directly correlated to Medicaid.)

B. How GME Legislation could effect medical education and health care in the future:

1. The caps do not adjust for population growth meaning that there will be a lack of trained physicians for some specialties (especially Emergency Medicine).
2. The caps do not allow for the creation of new technologically based specialties since current specialties must sacrifice trained physicians to cover newer specialties.
3. Restriction on Indirect Medical Education (IME) funding which is the larger share of Medicare funds to graduate medical education could cause some hospitals to close their residency programs, which would further reduce the number of resident positions available. This is uncertain as no one can truly predict the exact effect of IME funding on the number of residency slots.
4. It can redistribute physicians into preventive and geriatric specialties, which will become increasingly important in the coming years.
5. It can bring residents to rural areas and hopefully redistribute the physician population to less-served areas.

C. Medicare funds residencies through teaching hospitals in two ways:

1. Direct Graduate Medical Education Payments (D-GME)

This is the direct cost of resident training including resident salary, fringe benefits, attending physician compensation, etc. This is known as Medicare's contribution to the Per Resident Amount (PRA).

2. Indirect Medical Educations Payments (IME)

This is to cover the indirect costs associated with training residents including ordering more tests, longer patient stays, sicker patient populations, greater technological needs, and to offset the lack of private insurance's contribution to GME.

D. Medicare spending projections:

Fiscal Year	GME (in billions of dollars)	IME (in billions of dollars)
2002	2.4	5.7
2003	2.59	5.30
2004	2.7	5.8

E. Medicare capped the number of residents in 1996 with the Balance Budget Act of 1997, which was signed by President Clinton.

1. This cap does not apply to a residency program but to a teaching hospital. It does not prevent the direct creation of new programs but rather forces a teaching hospital to cut slots from another program to remain under the cap. Ex. If a hospital has 50 Internal Medicine residents and wants to have a 10 resident Emergency Medicine program – it must lower its number of Internal Medicine residents to 40.

2. Dental and Podiatric Residents are excluded from the cap.

3. IME and D-GME caps can differ per hospital. Ex. A resident that could be counted at an ambulatory facility as an FTE (Full Time Equivalent) resident for GME payments, but may not count towards the Intern Resident Bed Ratio (IRB) for IME payments.

4. Old urban teaching hospitals (meaning they received GME payments before 1996) cannot increase their cap except to allow for maternity and disability leave and this can only be up to three residents.

5. The Balance Budget Refinement Act of 1999 gave rural hospitals the opportunity for a 30% increase in their cap.

6. If a residency program voluntarily shrinks, then the government will decrease its payments using a three-year rolling average. (Ex. If a residency decreases the number of residents by 9, it will receive payment for 6 residents the first year, 3 the next year, and then finally receive the correct payment.)

F. The Drug, Improvement, and Modernization Act (DIMA) of 2003 also provides for redistribution of residents as follows:

1. Increasing slots

The DIMA of 2003 will allow some hospitals to apply for an increase of up to 25 slots in 2006. The regulations are not set but the priority will most likely be rural hospitals followed by small urban hospitals followed by hospitals that offer the only residency program such as emergency medicine or orthopedic surgery in the state. PRA will be at the locally adjusted national average and IME will be at a 2.7% add on.

2. Decreasing slots

In 2006, hospitals that are below their cap as of 2002 will lose 75% of the difference. Ex. A hospital with a cap of 100 residents that has 60 will receive payments for 70 residents since 75% of the difference is 30 residents.

Exceptions are as follows: small (<250 bed) rural hospitals, programs that expanded in FY 2003, and programs that voluntarily reduce in size. Those that reduce in size voluntarily lose their payments according to the three-year rolling average.

G. Counting the FTE status of residents calculating D-GME:

1. FTE status is determined by an Initial Residency Period (IRP), which is the minimum number of years required to become board certified in a specialty. For example, an internal medicine residency has three years, surgery has five years. Also, if an internal medicine resident who has completed one year of her residency program decides that she wants to become a surgeon only counts as a FTE resident for the first two years of her residency and a half an FTE resident for the last three years.

2. In sum – a resident must choose his or her specialty wisely from the start otherwise risk that the program director will probably not want to make the switch at the expense of the loss of income from the switch! However, there is no problem if a resident wants to switch to a residency program that causes his or her training time to be less than his original IRP.

3. FTE status for combined residencies (such as emergency medicine/internal medicine) is determined in one of two ways:

1. Two primary care residencies – IRP is the longer residency plus one year. ex. Internal Medicine/Family Practice would be four years since each residency has a three-year IRP.
2. One primary care residency with one non-primary care residency – the longer residency ex. Internal Medicine/Psychiatry would be 4 years since Family Practice has a three-year IRP and Psychiatry a four-year IRP.

NOTE 1: Further specialization beyond the initial residency period only counts as .5 FTE except for geriatric and preventive medicine. This gives hospitals incentives for having those specialties as residency programs.

NOTE 2: A general internship if required for certification in that specialty does not count toward the initial residency period.

H. Calculating D-GME Payments:

1. Medicare \$ = $\frac{(\# \text{ of medicare inpatient days})}{(\# \text{ of total inpatient days})} * (\# \text{ of Full Time Equivalent (FTE) Residents}) * \text{PRA}$

2. PRA is determined by a 1984 base level and updated for inflation using the Consumer Price Index – Update (CPI-U) and updated at a slightly higher rate for primary care residents giving hospitals a slight incentive to have a higher number of primary care residents.

3. The PRA which could be anywhere from 85% to over 140% of the locally adjusted national average in 1984 has remained as such except for hospitals exceeding 140% of the locally adjusted national average will not have their PRAs increased with inflation from 2004-2012. (The Balance Budget Reform Act (BBRA) of 1999 set the minimum PRA at 70% of the locally adjusted national average, and the Benefits Improvement and Protection Act BIPA of 2000 raised this number to 85%)

Note: In the 107th Congress, Senator Dianne Feinstein (D-CA) introduced a bill (S. 135) to increase the PRA of all residency programs with a PRA under the locally adjusted national average to 100% of the locally adjusted national average.

I. Calculating IME Payments:

1. Medicare adds a percentage of the reimbursement for Medicare cases done at teaching hospitals to cover the indirect costs involved in teaching residents as well as to make up for the fact that no other insurance provider funds graduate medical education. For example, if a Medicare patient needs a coronary bypass for which the reimbursement is \$5,000 and the percent add-on for the teaching hospital is 6%, then the hospital will receive \$5,300 for the case.

2. The **percent add-on** is determined by a multiplier determined by legislation and the Intern Resident Bed ratio (IRB).

The formula is as follows:

$$\% \text{ add on} = \text{multiplier} \bullet [(1 + \text{IRB})^{0.405} - 1]$$

The multiplier determined by legislation (for 2004 and beyond, by the DIMA of 2003) is as follows:

Fiscal Year	Multiplier	Approximate Corresponding percentage per .1 IRB increase
Pre-1997	1.89	7.7
1999-2002	1.6	6.5
2003	1.35	5.5
4/2004-9/2004	1.47	6
2005	1.42	5.8
2006	1.37	5.55
2007	1.32	5.35
2008 and beyond	1.35	5.5

(Sanner 2004, Slide 23)

Note: The percent listed here is slightly inaccurate – **the only numbers quoted in the legislation are the multipliers** – therefore, for the actual percent add-on, it is necessary to use the formula.

3. The BBA of 1997 was the beginning of the loss of IME funding as it sought to reduce the IME multiplier gradually from approx. 7.7% to 5.5% per .1 IRB. However due to much pressure from teaching hospitals, the DIMA of 2003 through the chart above attempts to increase IME payments to teaching hospitals by \$400 million in the next five years. Nonetheless, this is still a net loss for teaching hospitals compared to 1996.

J. Other sources of GME funding:

1. Medicaid: Funding is determined by Individual State – most have funding for graduate medical education although the mechanisms and amounts vary considerably. Most states are currently under pressure to cut Medicaid Programs.

2. Disproportionate Share Payments (DSH): Residency Programs tend to allow hospitals to serve low-income and uninsured patient populations, which cause them to hit the threshold for receiving DSH payments. **DSH does not pay for any graduate medical education directly** but instead provides the mechanism for hospitals to receive DSH payments which can put the hospital in a better financial situation than if it did not serve a low-income patient population.

K. Important Current Legislation:

1. S. 899 The Hospital Preservation Act of 2003, sponsored by Senator Hutchison (R-TX) would freeze IME payments at approximately 6.5% from October 1, 2004 and beyond. The corresponding bill in the house, H.R. 1710 is sponsored by Representative Mark Foley (R-FL).

2. S. 869 Assure Access to Mammography Act of 2003, sponsored by Senator Harkin, (D-IA) would have increased the cap on radiology residents by one per post graduate year starting October 1, 2003. The corresponding bill in the house, H.R. 817 is sponsored by Representative Peter King (R-NY).

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