

Graduate Medical Education Funding in Surgery

One of the most challenging concerns with implementation of a new residency program is the funding issue. There are only limited funding sources:

- Hospital (mostly Medicare, little Medicaid, DSH)
- School of Medicine (via DOD, Veterans Administration, Public Health Service)
- Department of Surgery
- Division of Cardiothoracic Surgery
- Philanthropy

Currently greater than 85% of funding comes from the hospitals through both direct and indirect Graduate Medical education payments from Medicare. Medicare capped the number of residents in 1996 through the Balanced Budget Act of 1997. This cap does not apply to residency programs but to teaching hospitals

In 1966, as part of the landmark Medicare law, the federal government assumed the responsibility for funding graduate medical education (GME) in the United States. The Medicare-Medicaid program pays hospitals, not medical schools, for the training of residents. Medicare-Medicaid payments to hospitals for training in surgery currently amount to about 93% of the total budget for GME, with the remainder coming from the Department of Defense, Department of Veterans Affairs, and US Public Health Service. The current federal budget for GME is approximately \$9 billion dollars per year, or approximately \$90,000 dollars per resident per annum. Medicare funds for GME are dispersed to hospitals in two forms: direct medical education (DME) payments and indirect medical (IME) payments. DME payments are intended to provide direct salary support for residents and partial salary support for teachers, as well as to defray overhead costs of the educational program. Total annual DME payments to a hospital are based on a historical per-resident stipend, which is then multiplied by the number of residents in the hospital and multiplied by the fraction of total hospital in-patient days that are Medicare patient days. IME payments are also based upon the proportion of services provided by the hospital to Medicare beneficiaries. IME payment levels also depend upon the ratio of residents to hospital beds. IME funds are intended to compensate for the greater patient care expenses that teaching hospitals incur as a function of providing GME. The IME component of payment to hospitals is approximately twice the amount of the DME component. In 1997, the Balanced Budget Act enacted by the US Congress froze the level of resident positions paid for by Medicare, as well as the rates for some parts of the funding. There is currently debate about whether funding for GME should be provided by a different government mechanism, such as an endowment, or whether the federal government should be funding GME at all.

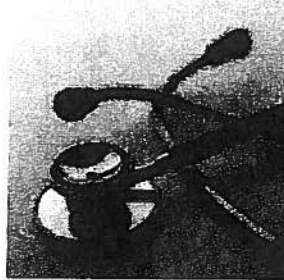
The issue of funding is also tied into the negotiations within the department and how the department uses uncommitted preliminary resident positions. Obviously if you try to obtain completely new positions you are likely due to fail because of the balanced budget act (as I am encountering at UW). If your department is large enough you may be able to negotiate internally to have one or more of the preliminary position become "designated preliminary" positions for your cardiothoracic integrated program. You might also be able to internally bargain for a categorical position to be designated for CT...I think you will encounter quite a bit of resistance even if historically one of the GS residents has gone into CT over the preceding few years...but because of the balanced budget act...in order to get more resident positions, someone has to give them up in order for someone else to get them...at least theoretically. If you have a

VA resident program within your system, there also may be then opportunity to shift resident positions from the VA. Such major shifts in funding would have to occur at the DIO level.

It is always hard to determine what an internal RRRC committee will use to prioritize requests. If we believe there is a fundamental need to change thoracic surgery education then this manual might help clarify those priorities. If the ABTS and TS RRC mandate such a change then local institutions might be under increased pressure to make the changes necessary or otherwise lose their cardiothoracic surgery training program (in the long run likely to be even more expensive to the institution). These issues will all be part of the discussion at the ABTS, TS RRC, and JCTSE levels and funding issues may be most critical to the discussion. The issue of lobbying for institutional support is also not clear. Whether every hospital religiously adheres to the Balanced Budget act for funding or resident or fellowship positions is also not clear to me and whether the balanced budget act equally applies to fellowship vs resident positions. I know I was strongly advised by our UW ACGME offices to use the next few months to rally support for our requests with both the ACGME office as well as the hospital. I know that our current GS program director is on the RRRC committee so hopefully she will be a strong advocate for our CT / Vascular requests.

I speaking with other program directors who have attempted to initiate an integrated program, funding consistently has been an issue. At Stanford there was little institutional support and funding was arranged through their foundation, ie extramural support. At Penn, there was little support and Mike Acker is not sure how often they will be able to use their integrated program format. At UT San Antonio, John Calhoon was able to bargain with the Department so that he will be able to use one of the uncommitted preliminary positions. At UW, we are submitting our request to the RRRC with Vascular Surgery for 2 new funded positions as a strategic move (knowing this past year there were 45 applications for new resident positions) . We have some assurances from the Departmental Chair that we will be able to use either a categorical or preliminary position...details to be determined.

Graduate Medical Education Funding



Prepared By:

**Rebecca E. Bruccoleri
Dartmouth College
Class of 2005**

Edited By:

**Braden J. Hexom
Legislative Affairs Director 2003-2004
Medical College of Wisconsin
Class of 2005**

amsa

**The American Medical Student Association
1902 Association Drive
Reston, VA 20191**

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:

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

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).

WORKS CITED/Bibliography

"AAMC Letter to CMS Administrator Scully Regarding Medicare Resident Limits." Association of American Medical Colleges. January 25, 2002. Available at:
<http://www.aamc.org/advocacy/library/gme/corres/2002/012502.htm>.

American Association of Medical Colleges. "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know." Washington, DC: Association of American Medical Colleges, 1997.

"Balance Budget Refinement Act of 1999 Interim Final Rule: Provisions Relating to Resident Limits," . Association of American Medical Colleges. April 15, 2004. Available at:
<http://www.aamc.org/advocacy/library/teachinghosp/hosp0047.htm>.

"Congress Passes Historic Medicare Prescription Drug Legislation," Association of American Medical Colleges. November 25, 2003. Available at:
<http://www.aamc.org/advocacy/library/washhigh/2003/112103/1.htm>

"Medicare Resident Limits," Association of American Medical Colleges. April 15, 2004. Available at:
<http://www.aamc.org/advocacy/library/gme/gme0012.htm>

"Medicare Direct Graduate Medical Education (DGME) Payments," Association of American Medical Colleges. April 15, 2004. Available at: <http://www.aamc.org/advocacy/library/gme/gme0001.htm>

Sanner, Louis, MD, MSPH, Associate Professor of Family Medicine, University of Wisconsin, Madison Family Practice Residency. "Review & Update on Medicare & Medicaid GME Payments to Hospitals, 2004." PowerPoint Presentation.

"Teaching Hospitals and Physician Provisions in the Balanced Budget Act of 1997" Association of American Medical Colleges. April 15, 2004. Available at:
<http://www.aamc.org/advocacy/library/teachinghosp/hosp0035.htm>



MedStar Health

January 7, 2009

Richard Feins, M.D.
3031 Burnett Womack Building
CB7065
Chapel Hill, NC 27599-7065

Dear Dr. Feins,

Thank you again for the opportunity to talk with you and your colleagues at the American Board of Thoracic Surgery regarding education in thoracic surgery. As you and your colleagues debate educational reform of your specialty training program, I would offer you some guiding principles specific to these issues for your consideration.

Hospitals receive reimbursement for their graduate medical education programs primarily from Medicare. There are two pieces of this payment, "Direct" or "DME" payments, and "Indirect" or "IME" payments. Direct payments are much easier to define and include direct costs that hospitals incur for the GME programs, including items such as resident salaries, teaching costs, ancillary services such as a medical library, etc.. Indirect payments are more difficult to define tangibly, but are intended to compensate hospitals for the additional cost and inefficiency of being a teaching hospital. For example, these payments are meant to cover things such as nursing inefficiency due to trainees, additional laboratory tests incurred due to the educational program, etc...

These payments to teaching hospitals are not insignificant. However, the payment amounts vary by hospital and some hospitals receive much higher payments than others. Generally, the IME payments are significantly more substantial than the DME payments. The payment methodology has evolved significantly over the past two decades, and hospitals now have "caps" that are placed on the number of residents that can be claimed for reimbursement. These caps are aggregate institutional numbers and therefore do not apply specific allocations or positions to individual residency/fellowship program. All residents physically rotating at a hospital are claimed on the Medicare cost report, and therefore one cannot choose which residents are claimed on the report and which are not. Many hospitals are currently over their caps, meaning they have more residents and fellows than they are actually reimbursed from Medicare. Given the financial challenges that many hospitals face in today's health care market, this is obviously an area that is constantly watched by our CEOs and other administrators who are sensitive to the cost/reimbursement balance that must be managed.

The number of capped positions a hospital is allocated for GME Medicare payments is relatively fixed. However, as mentioned above, the cap is an *aggregate count* for the institution and therefore the management of the institution has the discretion to determine how internal decisions are made relative to the finances and the overall cap

number. For example, Hospital A has a cap of 200, but their count is 210. If the internal medicine program is downsized from 50 residents to 30 residents, the cap will remain at 200 but the count would drop to 190. It is solely within the hospital's internal discretion to decide (a) to do nothing and submit a count to Medicare for 190; (b) whether or not they want to apply to increase the size of other existing programs, and if so, which program(s). Hospital A could very well decide they need more general surgeons, apply to the RRC for an increase, and if granted, have 10 more general surgery residents and still be at their cap of 200. Likewise, Hospital A could decide to increase each of their 10 internal medicine subspecialty fellowships each by 1.0 FTE.

Another aspect of the Medicare reimbursement to hospitals is related to the maximum training period for each trainee. Only residents enrolled in ACGME¹ accredited training programs are eligible to be listed on the Medicare cost report for the hospital to receive payments. For IME reimbursement, there is no limit to the amount of time a single resident can be claimed and the hospital receives 100% of the IME reimbursement for that resident. For example, if after completing internal medicine, the resident decides to do another residency or seek subspecialty training in an accredited program, the hospital would continue to receive 100% of the IME payment for that resident.

However, this is different for the DME payment. Once a resident completes an initial training period required for board eligibility in their specialty (i.e., five years for general surgery), the DME payment to the hospital then drops to 50%². This reduction remains in place for the remainder of any additional training that resident completes. This is important for you to note, as trainees in cardiothoracic surgery currently must complete a general surgery residency, and therefore once they start your subspecialty, their payments drop to 50% on DME, but continue to be 100% for IME.

Obviously, there is much more complexity to the Medicare payment system than what I have described above. But, as you discuss issues related to the restructuring of your curriculum with various stakeholders, it's important to keep these general concepts in mind. Given the current financial situation we are in, many hospitals will only agree to sponsor residency and fellowship programs for the accredited duration of the program, since any time enrolled in non-accredited training years cannot be reimbursed by Medicare.

Any initiatives that might be made to increase the number of training slots in thoracic surgery would ultimately need to be financed by the hospital or institution. A hospital administrator responsible for making these decisions is typically already faced with many other such requests to increase the number of trainees, and therefore the approvals are generally highly scrutinized and many are denied. In today's health care environment, additional funding requests in medical education are often "reserved" for those issues that are required (by ACGME or other regulators) or mandated. The day of acquiring additional expense because a department simply wants to make a change is long gone.

A mandated curriculum that entails one single pathway of thoracic surgery may have significant advantages. From a practical standpoint, a single educational pathway forces

¹ There are a few exceptions to this statement. Medicare also reimburses for residents enrolled in accredited training programs in podiatry (CPME) and dentistry (ADA).

² The determination of this time period has some flexibility. For example, if a resident takes a year off to do research, their "clock stops" for that year and resumes when they re-enter the accredited training program.

hospital leadership to decide whether they will sponsor an educational program or not. Sponsoring the program means investing in the essential requirements necessary for full accreditation of that program. The more options that are available only provides more discretion to the decision maker. On the other hand, a single pathway may also force the decision maker to simply close a program because the requirements cannot be funded. Without a mandate for a single educational pathway, attempts by a clinical specialty to make changes that require approval at a local hospital level would be difficult if not impossible to accomplish.

Speaking from my own personal experience, I would doubt that absent a mandate and a single educational pathway, any variation or additional approvals would be made at my institution, despite any other justifications or logic that could be applied.

I hope this provides you with the overview and information that will be helpful for you and your colleagues to engage in a meaningful discussion and reach a decision that furthers the rigor and longevity your specialty. Please feel free to contact me if there is anything else that I may assist you with.

Sincerely,

Jamie S. Padmore
Asst. Vice President
Academic Affairs