

Overview of the Financing of Graduate Medical Education

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BACKGROUND

Graduate Medical Education (GME), or residency training, is provided by formally-approved clinical education and training programs known as residency training programs, to physicians who have received a medical degree – the M.D. or D.O. degree in the United States – from an accredited or approved school of medicine. At least some GME is necessary to complete the physician's education and allow the physician to obtain a license to practice medicine: a physician must complete at least one year of U.S. GME in addition to the medical degree before he or she can obtain a license to practice medicine in the United States. In addition, completion of residency training in a specialty or subspecialty is necessary for a physician to be board certified in that specialty or subspecialty. Most physicians today complete at least one program of residency training.

GME is a complex enterprise involving substantial medical resources, including:

- Medical schools, teaching hospitals, and non-hospital teaching settings
- Bodies that approve GME programs, award specialty certificates, etc.
- Funding sources, including public and private third-party payers and appropriations

GME involves a significant portion of the total health care system:

- There were 96,410 residents on duty in ACGME-accredited (allopathic) programs on August 1, 2001, and 3,568 interns and residents in osteopathic training programs in that academic year, for a total of 99,978 residents in approved U.S. programs (fellows in approved programs are treated as residents in this paper).
- These residents are distributed across approximately 8200 allopathic and osteopathic residency programs in over 1200 teaching hospitals across the nation.
- The nearly 100,000 residents are one out of eight of the almost 800,000 active allopathic and osteopathic physicians in the United States.

A large number of private-sector organizations are involved in numerous, complex, direct and indirect ways in overseeing or relating to GME:

Allopathic

- Accreditation Council for Graduate Medical Education (ACGME)
- American Board of Medical Specialties (ABMS)
- Association of American Medical Colleges (AAMC)
- American Medical Association (AMA)
- American Hospital Association (AHA)
- Association of Academic Health Centers (AAHC)
- Council of Medical Specialty Societies (CMSS)
- Educational Commission for Foreign Medical Graduates (ECFMG)
- Federation of State Medical Boards (FSMB)
- National Board of Medical Examiners (NBME)
- National Resident Matching Program (NRMP)
- Accreditation Council for Continuing Medical Education (ACCME)

Osteopathic

- American Osteopathic Association (AOA)
- American Association of Colleges of Osteopathic Medicine (AACOM)
- American Osteopathic Healthcare Association (AOHA)

It should be noted that the Federal government has no specific role or authority over non-Federal medical education or GME, outside of the extensive regulation by Medicare of what and how it pays for GME.

GME FINANCING

The GME Picture

GME is provided by approved residency programs accredited by the ACGME or approved by the AOA. Completion of training plus meeting other requirements is a requirement for board certification in a specialty or subspecialty. (A small number of subspecialty programs are not accredited but lead to certification, and *vice versa*.) Most residency programs are sponsored by a hospital, medical school, or educational consortium; teaching hospitals serve as the sponsors and primary training sites for most. Training occurs in inpatient and ambulatory settings in teaching hospitals and a variety of community-based sites.

The ACGME has stated that GME is to provide an organized educational program with supervision and guidance as the resident takes on progressively greater responsibility. It relies on an integration of didactic activity in a structured curriculum with diagnosis and management of patients under appropriate levels of supervision and scholarly activity. In effect, the resident serves as an apprentice, providing patient care in a learning environment under the supervision of a teaching physician.

The GME Financing Picture

GME has evolved for over 100 years, from the establishment of post-graduation internships in 1889 through the specialty-by-specialty development of post-internship hospital training. During this time, GME has been strongly based in hospitals, and coverage of GME as hospital costs through inpatient hospital revenues from providing patient care services, has become well established within the health care system. Although this source is predominant, other sources include state and local appropriations and philanthropy. The need to move some of GME into non-inpatient settings raises persistent policy issues around how to cover the costs of ambulatory training

Major GME Financing Issues

- GME is funded by multiple sources, many not specifically directed to education:
 - Revenues for patient care
 - Funds for research, which indirectly support some of the GME infrastructure
 - Appropriations and grants by federal, state and local governments
- There are confounding issues in GME financing:
 - The funding of medical education is largely implicit in funds going to institutions for other purposes; even Medicare GME, which is labeled as education, is seen and treated by Medicare as a patient care cost. Other than Medicare GME, explicit funds for education are a relatively small proportion of total funds going to teaching hospitals and medical schools
 - Continuing payer support of GME may be made necessary by the absence of a focused system of funding it.
 - **Joint products** are pervasive in medical education; service and education are joint products that cannot be separated, physically or financially
 - GME revenues to hospitals are “fungible” – they go into a hospital’s general revenues, without requirement that they be specifically spent on GME; thus, the specific sources of most funds spent on GME cannot be identified
 - Like hospital services and education, faculty participation in GME is also a joint product that cannot be separated
 - Both undergraduate medical education and GME and their financing cut across both medical schools and teaching hospitals

- Many feel that teaching hospital financing is caught between education and service because of the lack of comprehensive health coverage, making Medicare and Medicaid GME and additional payments to hospitals that serve a disproportionate share of low-income patients (DSH) a necessity until solved.
- Public interest in explicitly paying for GME is suggested by the strong bipartisan congressional support for children’s hospital GME support.
- Although GME is part of the deployment of substantial medical resources, related expenditures are concentrated in a relatively small sector of one-fifth of all hospitals, particularly in “major teaching” hospitals with high resident-to-bed ratios: about one-half of all residents, and two-thirds of Medicare IME payments, go to fewer than 120 out of 1,300 teaching and 5,000 acute care hospitals.

Where do GME Funds Come From?

- Since GME is supported through hospital revenues, one can look at the percentages of hospital patient care revenues by source. Medicare provides only about one-third of hospital payments, according to data on national health expenditures from 1998:
 - \$123.9 billion [about **32.4%** of \$382.2 billion] came from Medicare
 - \$149.9 billion [**38.9%**] came from private health insurance and funds
 - \$60.8 billion [15.9%] came from Medicaid (including Medicaid DSH)
 - \$38.2 billion [10%] came from other, largely government, sources

In addition, a 1996 AAMC monograph, *Medicare Payments with an Education Label*, stated that Medicare provided 34.0% of DGME expenditures from patient service revenue.

- A 1998 survey of State Medicaid agencies for AAMC by the NCSL concluded that State Medicaid programs paid a total of \$2.3 to \$2.4 billion for GME in that year.
- In 1998, according to MedPAC, private payers were still paying hospitals at a 112% payment-to-cost ratio, while Medicare’s ratio was 101%, suggesting that private payments were at least as available for GME as Medicare’s, notwithstanding private payers’ not identifying any portion of their payments as “GME.”
- It is erroneous to hold that “only Medicare” or “only Medicare and Medicaid” pay for GME. Because these two payers support, at most, half of total GME costs, the remainder is necessarily supported by other payer funds, even though, because of revenue fungibility, it is not possible to identify most GME amounts by source. However, different views may occur on this point: hospitals may see non-labeled funds as a “bottom line” or “core funds” that they, not payers, provide for GME.

- Nevertheless, identifying specific amounts as “GME payments,” even if they do not represent the complete picture of GME financing, may place a public valuation on GME as a valued and supported activity, and provide a social “signal” of public direction and acceptability for all concerned.

How Medicare Supports GME

Medicare GME is supported primarily by the Medicare Part A trust fund, a social insurance mechanism financed through Social Security (FICA) payroll taxes to provide inpatient hospital services as an entitlement for those eligible by statutory criteria. Physician and outpatient services are covered under Part B, financed from general revenue and beneficiary monthly premiums. Constituencies such as elderly, the Congress, the AARP, and organized labor generally expect that Medicare funds will be used only for patient care.

- Because the Part A trust fund is financed through payroll taxes, the financial committees of Congress have sole jurisdiction over Part A – House Ways and Means, Senate Finance – carry out the function of proposing legislation authorizing Part A expenditures under the Social Security Act. It should be noted that there is no separate appropriations process under the payroll tax financing mechanism.
- Some Medicare GME is paid from the Part B trust fund, 75% financed by general revenues and 25% by beneficiary monthly premiums. Because of the general revenues component, Part B jurisdiction in the House is shared by the Ways and Means, and the Energy and Commerce committees; in the Senate, B jurisdiction is shared by the Finance, and the Health, Education, Labor, and Pensions committees.

Medicare GME payments are determined as follows (however, also see the section below on “Legislation [BBA, BBRA, and BIPA] Affecting Medicare GME, 1997-2000”):

- **Direct medical education (DGME)** payments to hospitals of a hospital-specific amount for each full-time equivalent (FTE) resident (under Medicare, resident physicians include allopathic, osteopathic, dental, and podiatric residents in hospital training programs) to help cover:
 - * salaries and fringe benefits of residents
 - * other costs including faculty physician supervisory costs
 - * allocated overhead
- The Medicare share of the per-resident amount is determined by:
 - * the hospital’s total per-resident cost, trended forward by the CPI from its 1983 per-resident cost, times —
 - * the weighted FTE number of residents [see MedPAC IRP recommendations below], times —
 - * the Medicare proportion of the hospital’s inpatient bed-days

- The Medicare FTE weighted resident count, established with the Prospective Payment System (PPS), was intended as a disincentive to specialization:
 - * residents must be in an ACGME- or AOA-approved residency program
 - * residents in their “initial residency period” (IRP) are weighted at 1.0 for determining DGME payments (see MedPAC discussion, below)
 - * residents past their IRP are weighted at 0.5 for payment purposes
- **Indirect medical education (IME)** is a hospital-specific percentage added to each Medicare DRG (diagnosis-related group) payment, as compensation for higher patient care operating and capital costs associated with teaching programs.
 - * operating IME payments are determined by the hospital’s intern/resident-to-bed (IRB) ratio, and currently increase by about 5.5% per 0.1 IRB.
 - * more precisely, IME is calculated by a logarithmic formula, $1.35((1+IRB)^{.405}-1)$, which decreases the increment as the IRB ratio rises
 - * the resident count is of unweighted FTEs in approved programs
 - * Medicare’s IME is only a share because only paid on Medicare patients
- The IME factor has always been higher than analytically justified. For many years, it was paid at the rate of 7.7% per 0.1 IRB, during a time that ProPAC, MedPAC and others were estimating the appropriate factor as 4.5 to 5.5%. MedPAC currently estimates it as 2.7%.
- Congress legislated a phased reduction in Medicare IME payments by reducing the IME factor, although political reaction delayed the final reduction until FY 2003:
 - * The BBA (1997) decreased it from 7.7% to 7.0% in FY 1998, 6.5% in FY 1999, 6.0% in FY 2000, and to 5.5% in FY 2001 and thereafter
 - * The BBRA (1999) froze the factor at 6.5% for FY 2000, decreased it to 6.25% for FY 2001, and delayed the drop to 5.5% until FY 2002
 - * The BIPA (2000) raised the factor back to 6.5% for FY 2001, kept it there for FY 2002, and delayed the drop to 5.5% to FY 2003
 - * The factor became 5.5% in FY 2003, which began October 1, 2002
- Amounts spent for GME must be modeled, since actual expenditures are currently too difficult to determine on a timely basis. It appears that MedPAC and others that formerly provided annual estimates of GME expenditures, no longer do so. MedPAC’s last estimate, in 1997, was about \$6.8 billion – \$2.2 billion DGME and \$4.6 billion IME, not including Medicare HMO GME dollars. HCFA and Congress estimated GME expenditures at about \$7.2 to \$7.6 billion in 1997.
- Nursing and allied health education expenditures, not included in the above amounts, are about \$250 to \$300 million per year. The number of programs receiving these

payments apparently has dropped each year as hospital-based programs continue to close.

- **Medicare prepaid health plans/Medicare+Choice**: Until the BBA, HMOs received a comprehensive payment including a hospital component for each Medicare enrollee, based on the local area's average Medicare Part A and Part B costs as reflected in the Adjusted Average Per Capita Cost (AAPCC) for the area. These amounts implicitly included local area teaching costs.
 - Thus, GME amounts were included in AAPCC payments, estimated at \$400 to \$500 million a few years ago, were neither identified nor paid in any relationship to an HMO's GME activities, which was a financial disincentive for HMOs to have GME or to use teaching hospitals. The rates that HMOs negotiated with teaching hospitals might not have fully included GME dollars.
- The BBA "carved out" DGME and IME amounts from the AAPCC over a 5-year period on a phased basis, reaching 100% by FY 2002; funds were to be made directly available to teaching hospitals, in accordance with Medicare DGME and IME payment policy, on behalf of hospitalized Medicare HMO patients.
 - In 1997, HCFA (now CMS) estimated that the carve-out would total about \$6.5 billion over five years, and amount \$2.6 billion in FY 2002 alone.
 - However, these funds are not set aside in a pool or automatically transferred to teaching hospitals. They must be obtained by the hospital through "shadow billing" to include these patients in establishing the portion of Medicare patients for determining DGME payments, and claiming IME portions. This could result in different expenditures than the amounts carved out.
- **Residents and GME in non-provider facilities (NPFs) –**
 - Provided that Medicare does not pay for GME activities carried out in an NPF, a resident even in an approved GME program can bill Medicare – the **only** place a resident can do so – under the following circumstances:
 - * the resident's time is **not included** in a teaching hospital's FTE resident count for DGME payments; and,
 - * the resident is **fully licensed** in the state.
 - * in such a case, the resident is billing **as a physician**, without regard to his/her functioning within the scope of an approved residency program; a faculty physician could not also bill for the service.

LEGISLATION AFFECTING MEDICARE GME, 1997-2000

Balanced Budget Act of 1997 (BBA)

The BBA enacted the first changes in Medicare GME payment policy in over a decade. These included limits for the first time on the number of residents that Medicare would pay for. The following summarizes the key BBA GME provisions:

- Applies to both DGME and IME payments:
 - **Caps**: The total number of physician residents which Medicare will pay for was capped at both a national and facility level. Each hospital's cap is based on its reported number of FTE residents from the last cost-reporting period ending on or before December 31, 1996. Dental & podiatric residents are excluded from the cap. The cap can be increased for new teaching facilities and programs, with priority given to rural underserved areas.
 - **Rolling averages**: Effective in cost-reporting periods beginning on or after October 1, 1997, resident FTE counts must be based on a rolling average for the hospital, over a 2-year period for the first such cost-reporting period and over 3-year periods thereafter
 - **Incentive payments** may be made for voluntary reduction of medical residents.
 - DGME and IME payments to teaching hospitals may be made on behalf of **Medicare+Choice managed care patients** in the hospital. These funds were to be carved out of implicit GME payments made to Medicare managed care plans over a 5-year period, rising from 20% in 1998 to 100% in 2002, and made available to teaching hospitals for hospitalized Medicare HMO patients.
- Applies only to DGME payments:
 - **Non-hospital providers**: Direct payments can be made to qualified non-hospital providers such as Federally qualified health centers (FQHCs), rural health clinics (RHCs), Medicare+Choice managed care organizations and other nonhospital entities if they incur the costs of operating an approved residency program (see next page).
 - **Combined specialty programs**: Full DGME payments are authorized for the additional year in approved primary care combined residency programs.
 - **Consortium demonstration**: A demonstration project was authorized to make DGME payments to medical education consortia (instead of teaching hospitals) meeting various requirements. However, a 2000 HCFA solicitation generated no applications to establish Medicare GME consortia.

- Applies only to IME payments:
 - **IME factor:** As described above, the IME factor was to be reduced from 7.7% per 0.1 intern/resident-to-bed (IRB) ratio to 7.0% in FY 1998, 6.5% in FY 1999, 6.0% in FY 2000, and 5.5% in 2001 and subsequent years.
 - **IRB ratio:** capped at the level of the preceding cost-reporting year.
 - IME payments to the hospital were permitted for interns/residents in non-hospital settings if the hospital incurs all/substantially all of the costs, as an incentive to hospitals to rotate residents to other settings.
- **MedPAC:** MedPAC was directed to make recommendations to Congress on long-term policies on teaching hospitals and GME within 2 years, on whether and to what extent Medicare payment and other Federal policies regarding teaching hospitals should be changed (see MedPAC discussion below).
- **Medicare GME support in non-provider facilities (NPFs) –**
 - Medicare DGME pays for GME in NPFs (free-standing clinics, nursing homes, physician offices, etc.), in two ways:
 - * Both DGME and IME can be paid to a hospital that rotates the resident to the non-provider facility (NPF) if the hospital covers the resident’s salary and fringe benefits and supervisory teaching costs in the NPF.
 - * Alternatively, the non-provider facility can receive the DGME directly:
 - in that case, however, neither the non-provider facility nor the hospital can receive IME payments for the time spent in the NPF
 - because the proportion of Medicare patients in NPFs is usually less than 10%, Medicare DGME payments to the NPF would be small
 - perhaps because paying GME to the hospital is advantageous to both hospital and site, no NPF has chosen to receive DGME

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA)

- The methodology for determining Medicare DGME payments to hospitals was modified to require calculation of a national average DGME amount, to determine a floor for a hospital’s direct payments at no less than 70% of the geographically adjusted average amount. For direct payments above 140%, hospitals would have their amounts frozen for two years, then increased by 2 percentage points below the CPI for the next 3 years.
- The “initial residency period” (IRP) for child neurology residents was established as the IRP for pediatrics plus two years. MedPAC was required to report to Congress on this issue by March 2001 (see MedPAC discussion below).

- The IME adjustment was maintained at 6.5% through FY2000 and reduced to 6.25% for FY2001, and the drop to 5.5% was delayed until FY2002.
- On/after November 29, 1999, hospitals were allowed to increase the FTE base year count by up to 3 FTEs for both DGME and IME for primary care residents who were on certain types of leave of absence. Other, similar modifications:
 - On/after April 1, 2000, rural hospitals could expand base year caps by 30%
 - On/after April 1, 2000, non-rural hospitals with separately accredited rural programs or tracks could have their base year limits “adjusted.”

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)

- The floor for Medicare DGME per resident payments was raised from 70% to 85% of the geographically-adjusted national average per resident amount.
- Changes in the IME factor reduction schedule delayed the 5.5% drop until FY2003:
 - The BBRA factor for FY2001 of 6.25% was raised back to 6.5%, the 6.5% factor was frozen through FY 2002, and the drop to 5.5% delayed to FY2003

Expanding Resident Numbers: In summary, resident numbers can only be increased above the existing caps in a hospital in a rural area beginning a new residency program, or by a non-rural hospital having a separately-accredited rural residency program track. CMS should be contacted for further details and specific application of these provisions.

MEDICAID GME

Medicaid is a large health program that has become comparable in size to Medicare, at an estimated \$240 billion in expenditures in 2002. It is a State-operated program that is financed by a combination of State (sometimes including local payment components) and Federal revenues.

The Federal government participates in Medicaid by matching, at various rates, dollars spent by the state (or locality, in some states). The state (or locality) must spend the “first dollar” in order to get the Federal matching – if the first dollar is not spent, there is no Federal matching.

Medicaid GME

A survey of states by the National Conference of State Legislatures for the AAMC* concluded that, in 1998, Medicaid spent \$2.3 to \$2.4 billion on GME. The report stated that this was about 7% to 8% of total Medicaid expenditures on inpatient hospital care, similar to the proportion spent by Medicare Part A on Medicare GME. It should be noted that the above range was based on states' survey responses, a variety of actual and estimated implicit and explicit reported expenditures. Although some states such as Illinois reported that they do not pay for GME, hospitals are free to shift their revenues within their institution. There is no reason to suppose that hospitals in those states did not use some Medicaid revenues to support GME in their institution, or that Medicaid definitively does not support GME in those states.

Most states historically have made GME payments under their Medicaid fee-for-service program. Indeed, the NCSL report stated that Medicaid is the second largest explicit payer of GME after Medicare. However, the advent of managed care in Medicaid changed some provider payment methodologies in substantial ways, and some of these changes appeared to place Medicaid GME support at risk. Specifically, while Medicaid managed care rates may include historical payments for GME, the managed care organizations are not obliged to distribute those dollars to teaching hospitals. A variety of growing pressures on state Medicaid agencies caused them to examine their GME financing policies more closely and to make changes in some cases. The report states some states have "carved out" GME payments from capitated managed care rates and rechanneled them to teaching institutions. Some states have also made policy linkages between distributed funds and training program accountability.

The report stated that 45 states and D.C. make some level of payment for GME under their Medicaid programs. Under their fee-for-service programs, 43 states and D.C. reported making GME payments; 23 of these reimbursed both direct and indirect GME, and 35 states distributed GME payments through the hospital's payment rate.

Under Medicaid managed care arrangements, while 42 states and D.C. had capitated Medicaid managed care programs in place, only 16 states and D.C. explicitly carved out GME funds and paid them to teaching hospitals or other programs under capitated managed care. (Two states reported making such GME payments directly to medical schools, not teaching hospitals.) Another 17 recognized and included Medicaid GME payments in their HMO payment rates, but largely assumed these would be distributed to teaching hospitals. Interestingly, ten states had linked their GME payments to state policy goals, such as training in certain specialties, often primary care, and training in certain settings such as ambulatory or rural sites.

CMS may be giving increased attention to Medicaid GME issues. Medicaid regulations issued in 2001 prohibited making separate carve-out GME payments to hospitals that were receiving Medicaid payments for patient care. After concerns were expressed about disturbing GME payment arrangements in many states, CMS in 2002 proposed a revision that would permit such payments to the extent that capitation rates are adjusted to reflect the GME payment. Unlike Medicare, GME had not previously been addressed in Medicaid regulations.

*Tim M. Henderson, National Conference of State Legislatures: *Funding of Graduate Medical Education by State Medicaid Programs*. Association of American Medical Colleges, Washington, DC, April 1999.

THE CHILDREN’S HOSPITAL GME PAYMENT PROGRAM (CHGME)

The purpose of this legislation is to provide explicit support for GME in the approximately 60 children’s teaching hospitals with their own Medicare provider number, called “free-standing” children’s hospitals. The program was enacted because Medicare GME support for free-standing children’s hospitals is almost negligible due to the extremely low proportion of Medicare patients. (Nationally, children’s hospitals’ payer mix is 40% Medicaid, 50% private pay, 4% uncompensated care, and less than 1% Medicare). In 1995, free-standing children’s hospitals received only \$400 per resident in Medicare DGME per year compared with about \$24,000 per resident across all other teaching hospitals. In addition, children’s hospitals are exempted from the Medicare DRG-based Prospective Payment System (PPS), and therefore do not receive Medicare IME payments which are part of the PPS. Instead, they receive cost-based payments under “TEFRA caps,” which, to the extent teaching hospitals have higher costs, result in higher payments that are somewhat equivalent to IME.

The absence of explicit GME support in children’s teaching hospitals prior to this legislation goes to the issue raised earlier: is at least some such explicit support desirable in order to validate and sustain the teaching mission of teaching hospitals? Moreover, residency training in children’s teaching hospitals is substantial: while accounting for fewer than one percent of all teaching hospitals, they are responsible for training about 30% of all pediatric residents, 50% of all pediatric subspecialists, and 4% of all residents.

The CHGME payment mechanism is modeled closely on how Medicare GME covers “direct” and “indirect” costs. However, Medicare payments are tied to its payments for patient care to Medicare beneficiaries; in contrast, CHGME legislation uses the Medicare rules to allocate a fixed appropriation that was apparently based on DGME and IME amounts received by typical non-children’s teaching hospitals. Unlike Medicare, the CHGME funds are general revenues appropriations and are not tied to specific payers or patient care payments.

The main differences between Medicare GME and CHGME are illustrative of the latter’s hybrid nature: while the payments of both are required to be based on Medicare’s resident counting methods for both DGME and IME, including caps and rolling averages, Medicare’s open-ended GME entitlement with formula-based instead of specific dollar amounts, contrasts sharply with CHGME’s dollars being limited to annual fixed appropriations and having to be prorated among the eligible hospitals based on formulas that are similar to Medicare’s.

CHGME appropriations rose from \$40 million in FY 2000 to \$285 million in FY 2002.

OTHER SUPPORT FOR GME

Private Payers

While all payers must implicitly cover a share of the costs of medical education, as described above, no figures are available regarding approximate amounts of either direct or indirect GME expenditures by private payers. As noted earlier, private payers perform support a substantial component of GME, since, for “direct” costs as defined by Medicare, Medicare pays only its share based on the Medicare percentage of the hospital's patient days.

For “indirect” costs, Medicare’s IME payments are made only for Medicare admissions, and therefore are not intended to cover the increased operating costs of other payers’ patients. While private payers have traditionally made higher payments to teaching hospitals, which could represent the equivalent of IME and perhaps DGME, there are no studies of how much the additional payments might be.

Some believe that private payers have continued to negotiate lower rates for teaching hospitals. While there are no detailed data on this, the March 2001 MedPAC Report to Congress provides an overview of the relationship of the insurance industry’s “underwriting cycle,” negotiations, and other factors as reflected in trends of Medicare, Medicaid, and private payer payment-to-cost ratios. Studies have shown that private payers have paid hospitals at above cost, but this is also true in Medicare GME, where Medicare has paid above costs because the IME factor has been paid at more than the analytic level.

Department of Veterans Affairs

The Department of Veterans Affairs covers the costs of residency programs in VA hospitals. The VA funds 8,840 FTE resident positions, nearly nine percent of the country’s resident positions. Approximately 28,000 to 32,000 residents, approaching one-third of all residents, rotate through these positions to receive some training at VA sites each year. FY 2000 funding for resident and other health trainee stipends totaled \$408 million, and another \$334 million was allocated to VA health networks for education support costs.

Department of Defense

The Department of Defense (DoD) covers the costs of residency programs within military hospitals, plus salary costs for military trainees at other programs. About 3,200 interns and residents are currently trained under DoD auspices.

Bureau of Health Professions, HRSA

The Bureau of Health Professions provides funds to primary care education and training programs, to enhance the quality of primary care training and to improve workforce composition and distribution. About \$93 million was spent in FY 2002 for this purpose

COMMISSIONS AND COUNCILS

Medicare Payment Advisory Commission (MedPAC)

- MedPAC is the principal ongoing advisory commission for the Medicare program, and is housed in Congress rather than the Executive Branch. Created by the BBA in 1997, it merged the earlier Prospective Payment Assessment Commission (ProPAC), responsible for Part A (hospital payment) issues and the Physician Payment Review Commission, responsible for Part B (physician payment) issues.
- MedPAC is made up of 17 Commissioners, prominent in economics, health policy research, executive leadership in health care systems including academic systems, and representatives of consumers, business and labor.
 - The Chair of MedPAC is Glenn M. Hackbarth, J.D., previously HCFA Deputy Administrator and Executive Vice President of the Harvard Community Health Plan, a teaching HMO. The Vice Chair is Robert D. Reischauer, Ph.D., President of the Urban Institute and at one time Director of the Congressional Budget Office.
 - The Executive Director is Mark E. Miller, Ph.D. The staff are largely economist in orientation.
- MedPAC is responsible for a remarkable breadth of Medicare financing issues, only one of which is GME. It is charged with issuing an annual March report which provides annual recommendations and topical reports on selected issues in June.
- **MedPAC GME recommendations:** The BBA mandated a special GME report on:
 - methodologies for making GME payments and who should receive payments
 - payments for training in nursing and other allied health professions
 - federal policies regarding IMGs
 - dependence of medical schools on service-generated income
 - dependence of schools of medicine on service-generated income
 - needs in next 10 years regarding physician supply in aggregate and by specialty, and financial effects on teaching hospitals
 - methods for promoting an appropriate number, mix, and geographical distribution of health professionals
- The Commission issued *Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals* in August 1999. Its principal recommendation was to combine Medicare direct and indirect payments as an adjustment to hospital payments for enhanced patient care, reasoning that GME costs are fundamentally patient care costs. MedPAC also recommended that payment adjustments should be developed in all settings where the added value of patient care justifies its higher costs. Emphasizing widely-held views in the Medicare policy community, MedPAC stated that Federal policies to affect number, specialty mix, and geographic distribution should be implemented through specific targeted programs rather than Medicare.

- The advantage of the MedPAC approach is that it would keep GME support out of shifting political sands and annual debates over appropriations.
- Nevertheless, the recommendation appears to have gained little acceptance – many feel it would emphasize hospital service over education and in-hospital training over that in a broader variety of settings, and tend to resolve the purpose of Medicare training support in the wrong direction.
- Merging DGME and IME does not provide a better justification for public financing of physician training, and seems to undermine historical payment distinctions that residents are in circumscribed training that precludes billing Medicare for services rendered.

The National Bipartisan Commission on the Future of Medicare

- This commission, also created by the BBA, was to make recommendations on the long-term financing of GME including consideration of alternative broad-based sources of funding for education and institutions not currently eligible for GME support but that conduct approved GME programs, e.g., children’s hospitals.
 - The draft final report apparently included a “Breux-Thomas” proposal that would move Medicare to a premium-based support model that would modernize Medicare fee-for-service and reform Medigap insurance and GME.
 - In the end, the Commission’s draft report and recommendations did not receive a majority vote, and the Commission terminated without a report.
 - The Breux-Thomas proposal would have recommended that:
 - * DGME payments be carved out of Medicare trust funds, and provided instead by a separate mechanism, as either a mandatory entitlement or a multi-year discretionary appropriation program
 - * children’s hospitals could be included in that mechanism
 - * IME would still be paid from Medicare Trust funds
- With respect to DGME, MedPAC and the Bipartisan Commission recommendations were the polar opposite of each other. This and the ensuing controversy over the MedPAC recommendations appears not to have resulted in a public consensus on how to pay for GME, and may have deterred it. Note, however, that both bodies would have continued to pay IME from the Medicare trust funds.

MedPAC Initial Residency Period (IRP) Recommendations

- The initial residency period (IRP) is the minimum number of years of residency training required to qualify for board certification, up to a maximum of five years. The BBRA charged MedPAC with making recommendations on the appropriateness

of the Medicare IRP, and whether it should be changed for combined residency training programs, and for programs that require preliminary years of training in a different specialty.

- Medicare allows full payment of its share of DGME for residents during their IRP, but only half of that share after the IRP is completed. This was instituted as a disincentive to producing more sub-specialists
 - * the IRP for a given resident depends on the specialty in which he/she begins, regardless of the specialty of the actual first certificate;
 - * thus, the IRP is, for example, 3 years for FP, IM and pediatrics, 4 years for OB/Gyn, 5 years for general surgery, etc.
 - * if a specialty requires four years of training but requires an initial year in specialty that requires only 3, e.g., FP, IM or pediatrics, the IRP is defined by that initial specialty, so that only 3 years of full DGME can be paid to the hospital and only one-half DGME for the other year
 - * however, some programs that incorporate such “preliminary years” into their program at the same hospital can get the full IRP for that specialty, whereas other hospitals cannot
- MedPAC, for its March 2001 Report to Congress, provided a detailed analysis on the issue, and recommended:
 - * that DGME weighting factors be eliminated
 - * all residents be counted equally through the first residency and subspecialty if pursued
 - * all Medicare DGME support beyond those parameters be eliminated

The Two Commissions’ Common Philosophies

There appears to have been a basic belief among these commissions’ members and staff, like others involved in Medicare policy, to not fund “education” costs out of Medicare trust funds, because their primary purpose is service to beneficiaries:

- MedPAC recommended combining DGME and IME into a hospital payment based on a patient care rationale rather than an education justification; the Bipartisan Commission was also prepared to recommend keeping the IME within the Medicare trust funds, although it would have moved the DGME to appropriations from general revenues.
- MedPAC recommended limiting DGME payments to one specialty and one subspecialty certificate, and eliminate all further Medicare DGME support

Council on Graduate Medical Education (COGME) Fifteenth Report

- COGME is an advisory body that reports to the Secretary and the health committees of Congress, but not the congressional financing committees. Nevertheless, its mandate includes making recommendations on changes in the financing of undergraduate and GME programs and the types of training in GME programs.
- COGME's *Fifteenth Report* presents a detailed discussion and set of recommendations on GME:
 1. Create an "all-payer" GME fund
 2. Make IME payments to non-hospital training sites if analytically justified
 3. Make DGME payments to program sponsors or their designees
 4. Create a national average per resident payment for DGME
 5. Continue but modify BBA caps on residents –
 - * apply caps to the sponsoring rather than the training institution(s)
 - * include residents who were in non-hospital settings in 1996 base counts
 - * allow adjustments of the BBA limits in areas with rapid population growth
 6. Create a separate account to fund special projects to build community-based capacity and achieve specific workforce goals
 7. Modify Medicare rules relating to teaching physicians' overall responsibility for management of patient care and reduce the importance of documentation
 8. Provide additional support for hospitals and community-based sites that serve a disproportionate share of low-income patients
- These recommendations are in the COGME tradition of viewing Medicare GME payments as (i) for education as well as service, and (ii) appropriate for supporting care of uninsured and other disadvantaged patients. These represent clear philosophical differences between COGME and the other commissions.
- Still, some recommendations (2, 3, and 5) are not necessarily inconsistent with current prevailing Medicare payment philosophies. For example, Congress is closing the gap in making DGME payments more uniform.

MEDICARE TEACHING PHYSICIAN BILLING AND "DOCUMENTATION"

This issue has been of intense concern in recent years because of the substantially increased recording burden placed upon faculty physicians in order for them to bill Part B of Medicare for patient care services while in their teaching role.

- Medicare has always taken the position that the law only allows Medicare physician payment for an identifiable patient care service rendered by a physician.
 - Medicare physician payments are fundamentally not for teaching.

- Medicare DGME, which is paid almost entirely to hospitals, covers the costs of teaching physician time spent supervising residents; the hospital then pays the physician for teaching, the only way Medicare was supposed to pay for supervising residents and administrative activities related to teaching activity.
- Audits and investigations over a 30-year period repeatedly found cases where teaching physicians billed for services performed by residents:
 - In the late 1960's and in 1971, the General Accounting Office (GAO) found that teaching physicians in some hospitals had billed for services carried out by residents, for whom Medicare had also paid the hospital.
 - 1972 legislation required that the physician him/herself had to provide the service in order to bill Medicare.
 - In 1986, GAO again found such activities, without evidence that they provided the service or with evidence that they had not done so.
 - In 1995, HCFA began requiring proof in the medical record that, to bill a fee, the teaching physician had provided the service. Regulations, which had never been implemented for the 1972 legislation, were finally issued in 1996.
 - The DHHS Office of the Inspector General carried out “Physicians at Teaching Hospitals” (PATH) audits in the late 1990s. Substantial repayments, often in the millions, were obtained from some academic medical centers. The audit process and findings were strongly contested by AAMC and others.
- As a result, CMS imposed documentation requirements, and teaching hospitals have imposed documentation requirements to head off any potential shortcomings during an audit. Documentation requirements have been the subject of lengthy negotiations between academic medicine and CMS.
- Underlying issues:
 - Congress and CMS have strongly considered “double payments” to be an important issue – they do not want to pay for patient care once through DMGE support of residents and then pay again for patient care through physician billing while providing supervisory services.
 - Medicare does pay for education, as a component within the DGME amount.
 - Medicare billing by residents is prohibited by law in provider-based settings, because they are or can be reimbursed via Medicare DGME (residents cannot bill Medicare even if the hospital does not claim the Medicare GME). Residents can bill only when training in a non-provider facility.

- The controversy around Medicare documentation requirements takes place only within the Medicare fee-for-service payment system; there is no Medicare involvement in plan-physician arrangements, an interesting policy disparity..
- Seemingly at the heart of the controversy are:
 - An apparent disagreement over concepts of payment for physician services by a resident under the supervision and authority of a teaching physician as part of developing a graded, independent responsibility of residents.
 - A philosophical disagreement regarding how teaching physicians should be paid: through hospital salary payments for teaching vs. fees for beneficiary services.

This issue has involved Congress, HCFA/CMS and its predecessors, the GAO, and academic medicine since 1967 – over a generation. An accommodation on the documentation requirements was finally reached with agreement on a revision to the Medicare Claims Manual of November 22, 2002, applying to certain evaluation and management (E/M) services. The revision allows the teaching physician to refer to a resident’s note, but still requires that the teaching physician must either perform the service or be present for the “key portion” of the service when performed by the resident, and provide personal documentation of his or her participation in the management of the patient. The combined entries of the resident and teaching physician constitute the documentation for the service. Scenarios and examples of minimally acceptable documentation were provided in these instructions.

- **The “Exception”** – Medicare also allows an exception by permitting Medicare payments to teaching physicians for services furnished by a resident without the teaching physician being present, in the case of certain office visit E/M services of lower and middle complexity. The following are the conditions for such payments:
 - The services must be furnished in a hospital outpatient or other entity in which resident time is included in determining Medicare direct GME payments.
 - Any resident furnishing this service must have completed more than 6 months of an approved residency program.
 - The teaching physician must:
 - * not direct the care of more than four residents at any given time
 - * be immediately available
 - * have no other responsibilities at the time
 - * have the primary responsibility for patients cared for by the residents
 - * review the care provided by the resident during or immediately afterward, and document the extent of his/her own participation

DISPROPORTIONATE SHARE (DSH) PAYMENTS

Medicare and Medicaid DSH (“dish”), while differing fundamentally in design, have similar purposes in protecting access for Medicare and low-income patients by assisting the hospitals they use. As suggested earlier, the lack of comprehensive health coverage may make Medicare and Medicaid GME and DSH hospital payments a necessity until it is solved.

Medicare DSH

Medicare DSH (like the IME), adjusts a hospital’s DRG payments upward, in this case according to 16 complicated formulas which differ by category of hospital defined such factors as location, bed size, and Medicare hospital status. Medicare DSH payments rose rapidly from \$1.1 billion in 1989 to \$4.3 billion in 1996, then stabilized at around \$4.5 billion per year since 1997, or approximately 6% of Medicare PPS hospital payments that year.

In spite of no direct programmatic or administrative link between Medicare DSH and GME teaching payments, there are a strong relationship and considerable overlap in hospitals that receive the two types of payments because many teaching hospitals also treat large numbers of Medicaid and other low-income patients. Notably, one-third of Medicare DSH payments went to 263 major teaching hospitals, or 1 out of 7 DSH hospitals and 1 out of 20 of all PPS hospitals, and two-thirds of all IME payments went to the major teaching hospital group. Combined, DSH and IME payments to major teaching hospitals constituted one-third of Medicare PPS payments to major teaching hospitals in 1997, and the IME itself constituted about 22% of major teaching hospital PPS income that year.

Medicaid DSH

Medicaid DSH, which was added to Title XIX in 1981, provides for increased Medicaid payments to hospitals that treat large numbers of indigent patients who are not eligible for Medicaid, in recognition of their inability to shift the costs of such patients to other payers, and of the disadvantaged financial situation of these hospitals. It should be noted that Medicaid DSH is much larger than Medicare DSH, in both dollars and proportion: Compared with Medicare’s \$4.5 billion, or 6% of Medicare PPS expenditures in that year, Medicaid DSH totaled \$15.5 billion in 1999, adding over 50% to the \$28.9 billion in regular Medicaid hospital payments. This includes both the federal and state share of DHS payments and does not account for intergovernmental transfers from hospitals that might have been used to establish the state’s share.

There appears to be an association between Medicare and Medicaid DSH payments. A study of Medicare and Medicaid DSH distribution to hospitals found that in FY 1998 major teaching hospitals as defined by 100 or more residents received 34% of Medicare DSH funds and 42% of Medicaid DSH funds.

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